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ABSTRACT

"A School Health Education Program for Appalachia" provides a holistic curriculum for grades K-7 by combining two validated health curriculum models. It has been implemented in three school systems located in the western section of Maryland. This evaluation focuses entirely on project implementation efforts in the three school systems with the objective of facilitating the dissemination activities which were the major mission of the project. Particular attention was paid to management functions and activities associated with the implementation efforts. The roles and functions of administrators and supervisors who played a managerial role in project implementation were studied and analyzed. Also examined were the ways in which teachers used materials essential to the program; how they scheduled activities; how they used resources; and how they planned for individual differences and needs. Attention was given to the role and response of the learners to the program and to the acceptance and support it received from local citizens--especially parents. Students were examined not only for their knowledge of program content, but for the attitudes and behaviors they developed as the result of this instruction and learning. Finally, the evaluation sought to explore "carry-over" or "spin-off" effects that the program may have had on other aspects of education. Curriculum outlines are included as well as the forms used as evaluation instruments. (JD)

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A Summary Evaluation of the
School Health Education Program
in Appalachia Maryland

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FOREWORD

"A School Health Education Program for Appalachia" provides a holistic curriculum (Grades K-7) by combining two health curriculum models developed under the auspices of the Center for Health Promotion and Education, Center for Disease Control of the U.S. Public Health Service in Atlanta. These curricula were combined by the Regional Education Service Agency of Appalachian Maryland into this school health education program being recommended to the school systems of the other states in Appalachia.

These models are the Primary Grades Health Curriculum Project (Grades K-3), sometimes referred to as the "Seattle Model," and the School Health Curriculum Project (Grades 4-7), sometimes referred to as the "Berkeley Model." These curricula have been validated for diffusion by the Joint Dissemination Review Panel of the U.S. Department of Education and the National Institute of Education.

RESA, with assistance of the Health Systems Agency of Western Maryland (HSAWM), introduced these two curricula into the three county-wide school systems in Appalachian Maryland (Allegany, Garrett and Washington Counties) over the past eight years. The holistic program is fully integrated into the Allegany County School System.

Demonstration grants from the Appalachian Regional Commission (ARC), through the Office of the Governor's Alternate to the Commission in Maryland, made it possible for RESA and the school systems to incorporate these health education programs into their curriculum. The grants were conditioned on RESA's producing dissemination materials which could assist in the infusion of this program into the school systems of Appalachia. Therefore, RESA has produced this publication for the "School Health Education Program for Appalachia" for that purpose.

For additional information about the program in Maryland, contact:

Executive Director
Regional Education Service Agency
of Appalachian Maryland
153 Baltimore Street
Cumberland, Maryland 21502
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A SUMMARY EVALUATION OF THE SCHOOL HEALTH EDUCATION PROGRAM IN APPALACHIA MARYLAND

Conducted by

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and Development
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College Park, Maryland

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Prepared for

The Regional Education Service Agency
of Appalachia Maryland
Cumberland, Maryland
Mr. George Allen, Executive Director

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For information about the program in Appalachia or for contacts in a specific Appalachian state, contact:

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1666 Connecticut Avenue, NW
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For detailed information about the Primary Grades Health Curriculum Project (Grades K-3) and the School Health Curriculum Project (Grades 4-7), contact:

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Atlanta, Georgia 30333

Acknowledgements

The evaluation team wishes to express its gratitude to those individuals who facilitated its efforts to develop a full and fair review of this program. Without their assistance and support, the evaluation could not have been carried out in the manner that it was.

One group of individuals who contributed greatly to the evaluation effort were the project directors for each of the three school systems--Mary Malamphy for Allegany County, Charlene Evans-Thomas for Garrett County, and William Ford for Washington County. These individuals assisted in the evaluation effort from the evaluation design stage on through the critique of the draft report and all of these efforts are deeply appreciated. However, the team was most impressed with the way in which each of them organized and managed the site visitations--they were exemplary. Their insights into the programs, the ease with which we were able to move from site to site within their systems, and the openness that accompanied every phase of our inquiry into the program were the highlights of our evaluation experience and will remain with us long after this evaluation is nothing more than a written record. Mary, Charlene, and Bill we shall always be grateful for the professionalism and the human warmth you displayed throughout this effort.

We are also grateful to the building principals who opened their doors to the visitation team and who graciously carried out those responsibilities which made our site visits pleasant and productive. We thank them for taking time to work out schedules for our meetings with their staff members and students, as well as for the early morning or late afternoon refreshments. We are extremely grateful to those who had us as luncheon guests.

We also wish to extend thanks to the teachers who opened their classrooms to us and who provided so many rich examples of quality teaching for our consideration. We thank them also for taking time from their classroom duties, often during their lunch or break time, to discuss the program with us. It was from these observations and discussions that we had a chance to discuss the real merits of the health curriculum we were reviewing.

The students we observed and visited with were marvelous. They added greatly to the positive feelings we now have regarding the true value of this program. While we could cite numerous occasions when the faces and voices of the students lifted our spirits and punctuated the warm and happy atmosphere that accompanies the study of their own bodies, one scene shall always remain in our memories--that was the occasion when an entire classroom of children broke into spontaneous song about the health unit under study.

We hope these acknowledgements help to convey the view that we, members of the evaluation team, were very impressed with all of you and your programs. If some of our negative comments have more hurt in them than we intended--and we intended none as our only purpose was to help you to improve upon that which you have so ably begun--then remember the warm and good feelings we all shared during those bright Spring days, and remember the faces and voices of the children who have gained so much from your efforts; for in the final analysis, it is they who are the most exact judges of your work. They say you have done well!

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PART I

EXECUTIVE SUMMARY OF THE SCHOOL HEALTH EDUCATION PROGRAM IN APPALACHIA, MARYLAND

Curriculum Overview

KINDERGARTEN - "Happiness is Being Healthy"
An introduction to the (5) senses and a look at feelings.

FIRST GRADE - "Super Me"
Learning more about taste, touch and smell plus how these senses affect the world around us.

SECOND GRADE - "Sights and Sounds"
The use and care of the eyes and ears.

THIRD GRADE - "The Body--Its Framework and Movement"
Ways to maintain healthy bones and muscles by gaining coordination, releasing energy, and exploring the world safely.

FOURTH GRADE - "The Digestive System"
Awareness of the digestive system and how to prevent problems and diseases.

FIFTH GRADE - "The Respiratory System"
Care of the lungs and the effects of smoking and pollution on the body.

SIXTH GRADE - "The Circulatory System"
Children learn ways to maintain a healthy heart through proper nutrition, exercise and recognition of risk factors.

SEVENTH GRADE - "The Nervous System"
A study of the brain - how we think, why we react the way we do.

IMPLEMENTATION OVERVIEW

Although comprehensive instructions are available for implementing the program, there are several highlights to consider in deciding on a system-wide or single school approach.

Starting

Assign a coordinator with management and supervisory responsibilities, preferably someone with elementary education background from your administrative staff.

Pilot the program at one grade level in a school where success can be anticipated and involve the school team in the planning.

Coordinating

The program cannot succeed without the complete involvement and support of the school principal.

Good leadership is critical for the success of the program. The responsible individual must understand and be committed to every facet of program management: materials distribution, scheduling, staff training and development, program supervision, and financial planning.

Training

The effectiveness of the program is directly dependent upon the training of school teams including the principal, teachers, and school health nurse.

Staff training must be ongoing as teachers are reassigned to areas in which they have not received training and new teachers are hired into the system.

Materials

Curriculum kits have been developed for each grade level which include teacher manuals, student work books, and instructional aids.

It may be necessary to assign specific responsibility for materials' control and allocate a large part of one clerk's workday to this task.

When materials are shared by several schools, the inventory, maintenance, and cross-checking procedures for materials kits need to be carefully worked out and adhered to in order to assure every teacher equal access to the materials.

Support

Initial cost to implement the program in one school will be about $120 per student. However, if the resources are shared by two schools, the cost is only $60 per student.

The per capita costs include the purchase of a kit, teacher manuals, student worksheets, and released time for teachers.

Commitment

To fully implement the program in the health curriculum of a school, it should be officially adopted by the Board of Education.

Periodic visits to the classroom by the superintendent serves to stimulate both teacher and student interest.

Background

This project was a joint endeavor of the Regional Education Service Agency of Appalachian Maryland (RESA) and the Boards of Education of Allegany, Garrett, and Washington Counties--all located in the Western most section of the State. Its major mission was to develop a dissemination model of a holistic health education program for grades kindergarten through seven. The dissemination model was to be based on the experiences of introducing, system-wide on a school-by-school basis, curricula combined by RESA of Appalachian Maryland into a single unified approach to health education. Assistance for this effort was provided by Health Systems of Western Maryland.

The project selected The Primary Grades Health Curriculum Project (Seattle Model) for infusion into grades K-3 and The School Health Curriculum Project (Berkeley Model) for infusion in grades 4-7. Both curricula were developed under the auspices of the Center for Health Promotion and Education, Center for Disease Control of the U.S. Public Health Service and the American Lung Association. They were validated for diffusion by the Joint Dissemination Review Panel of the U.S. Department of Education and the National Institute of Education.

This evaluation focuses entirely on project implementation efforts in the three school systems associated with the project. It accepts the validity of the curricula as determined by the agencies that developed and field tested them and makes no further effort to determine their value or appropriateness insofar as curricula goals, activities, and materials are concerned. By concentrating on the implementation efforts that were carried on in each of the systems, this evaluation seeks to facilitate the dissemination activities which were the major mission of the project. The evaluation attempts to

determine those practices and procedures which were employed by the implementing schools and school systems which have validity for other systems that may decide to introduce this curriculum into their educational programs.

This evaluation paid particular attention to management functions and activities associated with the implemention efforts. It studied and analyzed the roles and functions of administrators and supervisors who played a managerial role in project implementation. The findings support the critical nature of managerial planning, leadership, and control to the success of implementation efforts.

The evaluation also looked closely at the classroom scene—at the manner in which instruction and learning occurred as teachers and others worked to make the curriculum an active part of each student's life. In so doing, it examined the ways in which teachers utilized the materials which are so essential to the program; how they scheduled activities, how they utilized resources; how they involved parents and other community leaders; and how they planned for individual differences and needs. The findings here showed teachers playing a larger and more responsible role than usual in implementation efforts.

Attention was also given to the role and response of the learners to the program and to the acceptance and support it received from local citizens—especially parents. Students were examined not only for their knowledge of program content, but for the attitudes and behaviors that were being developed as a result of this instruction and learning. Once again the basic finding was enhanced by a very positive student response.

Finally, the evaluation sought to capture "carry-over" or "spin-off" effects that this program may have had on other aspects of education. It asked such questions as:

-Did the project provide a model for administrator and teacher planning which had applications in other educational areas?

-Did the project emphasize and develop teaching strategies and methods which were later found to be valuable in other instructional areas?

-Did the project, through its encouragement of community involvement and actual participation in classroom activities, develop closer relationships between teacher and parent? Between school and community?

-Did the project affect health attitudes and practices beyond the youth being served by the program? Were parents and other citizens having their ideas and behaviors challenged by what their youngsters learned at school? If so, how were these challenges being received and what was the response of these adult citizens to this approach to health improvement?

These issues and facts formed the basis for the design and implementation of this evaluation effort. They helped to determine the shape and selection of the evaluation procedures and strategies that were employed by the review team. They also guided the development of this report.

Evaluation Procedures

The evaluation was designed in accord with the principles and procedures adopted by the RESA Board of Directors as set forth in A Guide For Evaluating ARC Education Projects (September, 1981). The underlying principle of this document was that evaluation efforts be designed to assist project staffs and funding agencies to both judge and improve the worth of an educational project. Essential to that end was the requirement to include and involve appropriate project personnel in the evaluation effort in such a way as to effectively utilize their project knowledge and at the same time inform them on a continuing basis of evaluation findings and conclusions, without compromising the objectivity or the accuracy of the report.

The evaluation design called for a team approach. The evaluation team was involved in all aspects of the evaluation—from design to the writing of the final report--as were key project members of the three school systems in which the evaluations were conducted. Members of the evaluation team were all

experienced in the evaluation process and several had the beneficial experience of having served on earlier performance review teams. The team members and a brief statement of their educational experiences follows:

Ms. Carol Bittner, assistant principal for Ridgeley Primary/Middle School, Ridgeley, West Virginia. Ms. Bittner has served in several capacities as a consultant/advisor to RESA activities.

Dr. Thomas Palardy, assoc. prof. elementary education, Frostburg State College, Frostburg, Maryland. Professor Palardy served on an earlier review team that evaluated the Primary Grades Health Curriculum Project.

Mrs. Maureen Palardy, ass't. prof. early childhood education, Frostburg State College, Frostburg, Maryland. She also served as a member of the evaluation team that conducted a performance review of the Primary Grades Curriculum Project.

Dr. Lewis Patterson, Evaluation Specialist, Regional Education Service Agency, Cumberland, Maryland. Dr. Patterson has had extensive experience in the area of his specialization.

Dr. James Dudley, Director for the University of Maryland's Center for Educational Research and Development. Dr. Dudley served as chairperson for the evaluation team. He has conducted numerous evaluation studies at the national, state, regional and local levels. He recently conducted nine evaluative studies of ARC funded projects for RESA.

Two separate instruments were designed for data collection purposes. The Health Curriculum Project Evaluation Form I was completed by the local project supervisor with the assistance of other local personnel as needed. Form II was designed for use by members of the evaluation team at the time of the site visit. (Copies of Form I and Form II are provided in Appendix B.)

Form I was a nine page instrument with six separate sections or parts. It was designed to gather descriptive data about the project's current status; significant implementation steps and procedures; project maintenance efforts and activities; noteworthy project adaptations; noteworthy project accomplishments; and plans for the improvement of the project over the next five years.

This form was completed in each case by the local school system person charged with overall supervisory responsibility for program activities. Each supervisor completed two copies of the form--one for the primary grades or Seattle Model and one for greades 4-7 or the Berkeley model. Data from these instruments were shared with evaluation team members prior to each site visit.

Form II was designed for use by members of the evaluation team during the site visitation. It provided for a combination of interview and observational data. It was anticipated that each team member would complete one copy of this five-page form at each of the sites visited; about four instruments per team member for each of the three days devoted to site visits. It was not expected that all portions of either the interview schedule and/or observational schedule would be completed at each of the "stops" as questions were not necessarily appropriate at every level or for every position being interviewed.

This instrument was designed in such a way as to provide some cross validation of the data obtained on Form I, as well as to obtain new data on project operations. Part I was used to gather interview data from central office personnel, school principals, classroom teachers, students, and community leaders and parents involved in program operations. It consists of four separate sections, each dealing with different aspects of the interviewee's perceptions of the way in which the program operated, the training and support provided, the quality of program management, concerns and expectations for the program's future, and noteworthy aspects of program results.

Part II of Form II was structured to gather observational data on each site visited. Team members were expected to complete this section as they observed in classrooms, walked through the building, or sat in on group meetings. The form provided space for informational entries on such areas as management, leadership; personnel preparation, pupil responsiveness, community involvement,

and noteworthy achievements. While team members found this form a little difficult to follow and some preferred a less structured approach to data gathering on site, over fifty of these forms were completed (in full or in part) during the three days of site visits. Team members were responsible for summarizing all data collected at the end of each day of visitation and for sharing highlights of their summaries during the follow-up session that concluded each day of visitation. These data summaries and the completed forms for that site visit were then handed or mailed to the team chairperson for use in assembling the final report.

Major Findings

The major finding of this evaluation effort was that the efforts to implement a holistic health curriculum in the three school systems of Western Maryland--Allegany, Garrett, and Washington counties--has been highly successful in Allegany County and somewhat less successful in Garrett and Washington Counties. All three school systems have been highly successful in their efforts to implement the Primary Grades Health Curriculum Project (Seattle Model), but only Allegany County has been successful in implementing and maintaining the School Health Curriculum Project (hereinafter referred to as the Berkeley Model) for grades 4-7. Garrett County has withdrawn the Berkeley Model as a systemwide project and it currently remains active in two classrooms. Washington County has components of the Berkeley Model active in a number of classroom settings, but lacks the materials to implement it systemwide. It has decided to refine the Berkeley Model to its program needs at the fourth and fifth grades levels, preserving what it feels is the "Best of Berkeley."

Everywhere we visited, we found unrestrained enthusiasm and support for the School Health Curriculum. From central office administrators and supervisors to

classroom teachers and students, we heard words of praise and support. Numerous students stated that health was their favorite school subject and several teachers commented on the fact that the curriculum was fun and exciting to teach. Parents and other community leaders echoed these sentiments.

We found leadership to be very well dispersed throughout the staff. While the highest level of commitment and responsibility seemed to rest with the three program directors, there was some evidence of leadership at the building administrator level and a considerable amount at the level of the classroom teacher.

We found close ties between the program and the community. Community resources, both human and material, were seen as important to program success. Numerous community agencies and organizations--both public and private--shared in the implementation efforts.

We found some decline (compared with impressions of earlier visits) in program activity and enthusiasm in a few places. This may have been due to a general maturing of the program to the extent that its newness had worn off. Nonetheless, the lessening of public information releases and the failure to keep the program in the forefront of community thinking could, in the long run, have injurious effects.

Our findings indicate that implementation efforts had a salient effect on a wide range of topics:

-Pupil enthusiasm and interest in their persons was heightened as was there sensitivity to the feelings and wellbeing of their fellow students.

-Pupils evidenced a great awareness and understanding of their body systems and of the need to keep them healthy.

-Teachers reported that the curriculum reached students who, up to that point, had been unreachable. They reported students reading and responding to program materials at a level far in advance of what had been the case.

-Teachers indicated that the program had given them new motivation and new tools for teaching.

-Parents and teachers reported seeing both behavioral and attitudinal changes in students regarding the use of drugs, alcohol, and tobacco. Some students were reported to have "pressured" their parents to give up the use of these products.

-The school environment was enriched with the health story. Walls, bulletin boards, and murals everywhere carried the theme of the health unit being taught.

-Parents were evident as teacher aides whereby station work was underway. Parents indicated they enjoyed their role as volunteer aides.

-Administrators indicated that the program had had a beneficial effect on their schools, and on school community relationships. They and teachers reported a lot of community interest in health maintenance.

We found evidence of high quality teaching in a large number of settings. Teachers and program administrators attributed this to the high quality workshops that the teachers attended. Teachers cited the quality of the program activities and materials as stimuli to their teaching.

There was ample evidence that the summer workshops for administrators and teachers were very beneficial; both in terms of the high level of performance on the part of those who attended and the hesitancy that marked the performance of the few who did not receive training.

There were, of course some negative findings. We were disappointed to find that past program mangers had not always performed well--at both the central office and building levels—and that these lapses resulted in both a loss of materials and support. The downfall of the Berkeley Model in two of the systems is directly attributed to management failure at several levels.

We felt that in some instances the programs were initiated without benefit of a solid management plan. This omission permitted lapses in responsibility and resulted in management's failure to adequately monitor and correct program deficiencies at an early stage. There also appeared to be little effort on the

part of building administrators to call this problem to top level managements attention and/or to fill the void until the situation could be corrected.

We found evidence of materials nonmanagement in the early stages of implementation in several situations. This failure to adequately manage and control the distribution and inventory of materials proved to be critical to the failure of the Berkeley Model to survive in two of the systems.

Major Conclusions and Recommendations

It is the overall conclusion of the evaluation team that the School Health Education Program which has been implemented in the three Western counties of Appalachia, Maryland is an excellent program for grades K-7 and merits further dissemination in the Appalachian Region as well as elsewhere in the State of Maryland. The program's design and instructional approaches facilitate learning for a wide range of learner abilities and interests.

It is also the conclusion of the evaluation team that the initial outlay of funds for program materials is money well spent in terms of the potential return to students, teachers, and community. The program may be especially well suited to areas that seek to reduce the incidences of smoking, drinking, and drug use and/or where there seems to be a low regard for personal health.

The evaluators strongly recommend that implementation efforts proceed from a comprehensive plan that adequately defines responsibility and which provides the appropriate administrative monitoring techniques. Materials inventory and control are essential to program success, especially where system resources are such as to require sharing of materials among several schools.

Top management must support implementation efforts throughout and must act positively to assure leadership and commitment at all management levels throughout the implementation chain. In that respect program managers, including principals, should be required to participate in the training sessions.

Training sessions need to be provided for all professionals associated with the program. There needs to be provision for training follow-up every two or three years so that classroom teachers can be continuously upgraded in the area of health knowledge and skills. Community resource people need to be involved in these sessions, both as trainees and trainers. There needs to be, at the school level, training programs for teacher aides and parent volunteers.

The evaluators strongly endorse the position that boards of directors give their full endorsement and support to the program prior to implementation. They need to be informed as to program costs as well as program benefits.

The system considering implementation needs to put into place an excellent program of public relations so as to inform the community about the program and its elements. While the program should not be offensive to any group, there are program components which may upset an uninformed community.

In addition to the program of community relations, there should be a systematic plan and effort to involve community health agencies and health related agencies and institutions in program implementation. Many of these have access to excellent free or inexpensive instructional materials and all have excellent human resources which can benefit the program

PART II

PROGRAM DESCRIPTION

Background

Project Origins

The Regional Education Service Agency of Appalachian Maryland (RESA) and the Health Systems Agency of Western Maryland (HSAWM) have introduced two health education curriculum projects to the three county-wide school systems of Appalachian Maryland (Allegany, Garrett and Washington Counties). These projects were made possible by grants obtained through the Governor's Office in Maryland and the Appalachian Regional Commission (ARC) with funds from the Appalachian Regional Development Act.

The two curricula are the Primary Grades Health Curriculum Project (Grades K-3) and the School Health Curriculum Project (Grades 4-7). These projects were developed under the auspices of the Center for Health Promotion and Education, Centers for Disease Control, U.S. Public Health Service. The curricula have been validated for diffusion by the Joint Dissemination Review Panel of the U.S. Department of Education and the National Institute of Education.

RESA has adapted these two curricula into a holistic curriculum (K-7) entitled School Health Education Program for Appalachia.

The combined curriculum is aptly described in a U.S. Public Health publication as follows:

> "The [program] is a curriculum, a method, and a training program. It focuses on the human body and the maintenance of that body in good health. It involves and motivates the students, teachers, principals, school district administrators, school health staff, other school staff, community resource people, and voluntary agencies, and the students' families. It enhances other school subjects, such as reading, writing, arithmetic, science, and the creative arts. The project is fully integrated with life and personality development of the children by providing situations in which the children assume responsibility, make decisions, share knowledge, research ideas, and create activities to illustrate their comprehension and their internalization of concepts and attitudes.
>
> "As a health curriculum, [it] is comprehensive, that is, it is life-related. It is not only comprehensive of the subject matter as health and disease, but also in its approach of integrating classroom learning experiences with other life situations and activities and people contacts. It is designed not only to affect the child, but also to involve all aspects of his world--his classmates, teachers, family, and community. It leads a child to see that one's body is one's greatest asset, one's greatest resource for thought, activity, and relationships throughout life."

The two model curricula are wholly in place in the Allegany County School System and partially in place in Garrett County and Washington County School Systems. Some schools and some teachers in the adjacent West Virginia County Systems have adapted some elements of the curriculum but they are not directly identified with the project. The adjacent Pennsylvania school systems have no elements of the curriculum.

Project Management

The School Health Education Program, referred to as the Berkeley Model, was brought to RESA's attention by the Health Planning Council of Western Maryland, the predecessor of HSAWM. The three superintendents who were on the Board of Directors of RESA recognized the importance of the model curriculum and as a result the Board decided that RESA should assist the three systems in its implementation.

RESA combined some of its own funds with significant grants from the Appalachian Regional Commission and the Maryland Regional Medical Program under a three-year regional demonstration program with RESA staff coordination. The program commenced in 1974.

Each system assigned a staff person from their central offices to administer the implementation of the program. Funds from the grant enabled RESA to provide a full-time coordinator in each county to assist the administrator in the implementation. In two counties, a certified teacher was recruited as coordinator from the school system who granted them a leave of absence. They returned to the system after the third year. The coordinator for the third system came from outside the system and thus was not retained upon completion of the three-year demonstration.

The curriculum model for grades 5 through 7 was introduced into each of the three systems a grade at a time beginning with the 5th grade, followed by the 6th and 7th grades. These grades were the only ones available at the time of the demonstration grant application.

The regional coordinator in the RESA office and the county coordinators assisted the system administrators in the training of school teams, the scheduling of schools, and in the distribution of the instructional materials and aids. RESA purchased the materials and aids and reimbursed the systems for released time of the teachers. The cost of the materials required the sharing of materials and aids between two or three schools.

By the end of the three-year demonstration (1977), the fourth grade of the Berkeley model became available. This was introduced into each of the three counties during 1978 by the regional coordinator and the three administrators based on the previous experience.

Each of the three systems was to maintain the curriculum without further funding and assistance from RESA.

In 1981, RESA obtained funds from the Appalachian Regional Commission for what was expected to be a three-year grant to implement the Primary

Grades Health Curriculum Project (K-3), known as the Seattle Model. This model provided for the introduction of all three grade levels at the same time in a school at a time.

It was anticipated that a third of the schools across the three school systems would introduce the curriculum each year over the three-year grant period. However, because of funding problems at ARC, the implementation funds were reduced and the project was modified to implement the program over two years.

The management and delivery mode by RESA and the three systems for the Primary Grades Project was the same as that for the Berkeley Model except that no county coordinators were provided. The regional coordinator at RESA and the administrator in one system in one of the three counties were the same for both projects. The other two systems had a change in assignment of county administrators.

The demonstration grant for the Primary Grades Project was predicated on RESA's preparing a set of materials for possible dissemination throughout the Appalachian States as a holistic program (K-7). These materials included a summary evaluation of both projects; the preparation of informational publications for superintendents, school principals, and parents; and a prospectus for health education centers reflecting the holistic curriculum for community health education needs.

Introduction

The School Health Education Program in Appalachia, Maryland is a holistic curriculum for health education which integrates two curricula models that had their beginnings some fifteen years ago. These two models are The School Health Curriculum Project (Berkeley Model) and The Primary Grades Health Curriculum Project (Seattle Model). The School Health Curriculum Project preceded the Primary Grades Project by several years and was designed to serve the health education needs of students in grades 4-7. The Primary Grades Health Curriculum Project was developed as a companion project to the School Health Curriculum Project and "sought to provide the same high quality experiences about health for boys and girls in the primary grades (K-3) of school." The following two sections provide a brief overview of each of the two curricula and a statement that lays out the sequence of events that accompanied the implementation efforts of the School Health Education Program in Appalachia, Maryland.

Overview of Berkeley and Seattle Projects

The School Health Curriculum Project was begun in the late 1960's by educators who recognized the void of relevant school health education in the nation's schools. The project's orientation from the beginning was disease prevention through the elimination of practices which were known to be major contributors to disease and illness. Hence, early administrative and financial support was later provided by the Bureau of Health Education, Center for Disease Control, Public Health Service, Department of Health, Education, and Welfare.

The "goal of the School Health Curriculum Project is to help the child realize that the body is each person's greatest natural resource in life, and that its condition is influenced by one's own choices made throughout life." The curriculum is comprehensive in that it is life-related and in that it seeks to integrate classroom learning experiences with other life situations. It is designed not only to affect the child but to include all his school and out-of-school associates.

The School Health Curriculum is a curriculum, a method, and a training program. As a curriculum it includes a nine week teaching unit at the fourth, fifth, sixth and seventh grade level on the functions of the various body systems. As a method it seeks to individualize instruction so that each learner, regardless of ability, can acquire the essential ideas, facts, skills, and attitudes. It utilizes a learning center (stations approach) that makes use of the entire school facility and community and it attempts to integrate health education with all other facets of the educational program. It is a training program that seeks to provide both teacher and learner with an approach to learning (exploration and discovery) which will enhance and guide future learning teaching.

The program activities are "real to life." Children, under the guidance of well-trained teachers actually feel, observe and, in some cases, manipulate real animal organs to develop life-like responses for study and analyses. The curriculum makes use of many materials that are prepared for adult reading. These richly illustrated materials are often free from the sponsoring agency.

Perhaps most important, the curriculum seeks to put the learner in charge of his own destiny. It makes healthful living the responsibility of each person and dramatically illustrates the advantages of forming and practicing good health habits and attitudes and of avoiding those choices which are injurious to health.

The School Health Curriculum is presented in brief review in a 1977 publication of the U.S. Department of Health, Education and Welfare (now the Department of Health and Welfare) and is available by requesting Publication No. (CDC) 78-8359.

The curriculum underwent design refinement at Berkeley. Hence the title School Health Curriculum Project: Berkeley Model. These two names are used throughout this report to identify the curriculum for grades 4-7.

The Primary Grades Health Curriculum Project is the result of cooperative efforts put forth by the Bureau of Health Education and the American Lung Association to develop a program for the primary grades which would be of the same high quality as the School Health Curriculum Project. The units were originally within and developed within the Seattle School District (hence the name the Seattle Model which is used freely in this report to identify the program for the primary grades), then tested in four sites in different areas.

The curriculum builds on the natural curiosity of young children—it begins with the questions children ask about themselves and their personal development. Methodologically it patterns after the Berkeley Model in that it creates opportunities for exploration and discovery largely through the use of learning stations.

The activities are designed to have children share their ideas and their feelings and in that way to use one another as a learning resource. Valuing of self is an important program goal as it is assumed that individuals who place a high value on self will more likely be inclined to take care of their bodies and health.

In its comprehensive approach, the Primary Grades Curriculum Project considers each learner in two contexts:

1. the context of an entire life to live, and
2. the context of an entire education.

The curriculum is conceived of as a learning system consisting of five parts:

Part I is its health content--the body as a network of senses and feelings that interact with other body parts that need to be cultivated and cared for.

Part II is its learning/teaching method--the use of small group learning centers where learners can explore, discover, and share.

Part III is its training program for teachers and administrators--active involvement of professionals in activities similar to those their students will be experiencing, and hopefully, enjoying.

Part IV is its community development--extending learning and teaching beyond the classroom and which brings that community into the school and classroom.

Part V is its integration with other subject areas--reading, writing, math, art, music, drama, science.

Subject matter is organized into a sequence of five phases designed to be taught over a ten or twelve week period. The organization is as follows:

Introduction--Curiosity Arousal

Phase I: Overview of Feelings and the five senses. (K-2 or the body systems in grade 3).

Phase II: Appreciation of specific senses (K-2 or grade 3).

Phase III: Structure and Function of the senses (K-2) or grade 3.

Phase IV: Diseases and Problems of the senses (K-2) or grade 3.

Phase V: Care of the body and disease prevention.

Culmination: Synthesis of previous phases.

These two curriculum provide the basis for the School Health Education Program of Appalachian, Maryland.

Specific Implementation Activities

This section of the instrument was designed to determine specific implementation procedures followed in each of the three systems. It was anticipated that this information would prove useful to the dissemination effort in that

it would indicate actions that appear to be related to successful implementation as well as to support what can go wrong. The latter can be important in indicating where program monitoring needs to be closely adhered to and where corrective action needs to be considered.

Management and Supervisory Responsibility

All three systems indicate that program management and supervisory responsibility have been clearly defined and established at this point in time. However, there was a variance in how these systems arrived at this state and there is some correlation between the time it took to achieve this status and implementation success.

In the one system where both the Primary Grades and School Health models are fully in place, program responsibility was defined and established at the outset and assigned to an existing role within the organization.

In a second system where the Primary Grades is fully implemented but the School Health Project survives in only four elementary schools, the responsibility for program management was assigned to an internal person but the system now questions the appropriateness of that assignment as well as the clarity of the responsibilities that accompanied it. Recently this responsibility has been clarified by the system and assignment has been shifted to another role and individual within the system.

In the third system, one in which the School Health Project has failed to survive while the Primary Grades is fully implemented, these were acknowledged problems in project management of the component. At the outset project coordination for implementation was assigned to an individual whose salary was paid for from implementation funds provided by RESA. This individual held no other role in the system during that period and was able to devote full time to project coordination. Due to a high level of personal skills and

sufficient time to care for details personally, he operated at a level that the system judged to be effective. None-the-less there was no evidence that either he or the system develop a clear and systematic management plan for program implementation. When (RESA) funding was no longer available to support the coordinator position, project responsibility was assigned to an existing role within the system. The individual assigned the responsibilities, a supervisor of physical education with a strong secondary orientation, resisted the new assignment from the outset and the system provided him with no systematic plan for managing the various program elements. After two years of mis or non-management, this individual was replaced by the current project manager who has had responsibility for the Primary Grades program from the beginning. That program has an excellent management plan, responsibilities are much more clearly defined, and the program manager evidences high personal and professional commitment to its goals.

The responsibilities of these individuals are broad in nature and cover every facet of program management and supervision: materials distribution and control; scheduling; staff training and development; program supervision; and, in one instance, financial planning. All three respondents indicated that they felt their programs were "currently" well managed. One indicated that only routine difficulties had to be dealt with, but the other two administrators reported that some major difficulties confronted their projects, some of which had been resolved and some which still needed resolution.

Project Implementation Procedures

Introduction

The "Primary Grades Program" (K-3) and "School Health Project" (4-7) differ very greatly in terms of their current status. Whereas the Primary Grades program appears to be "fully" implemented in all three systems, the School Health Project

is only "fully" implemented in one system and "partially" implemented in the other two. Therefore, the Primary Grades and School Health Project are described separately in the two sections that follow. Thereafter, the report follows the more logical pattern of discussing the two project jointly.

Primary Grades Program

Two of the three counties indicated that the Primary Grades Program is fully in place throughout the system with all schools participating. The third system indicated that the program is only partially in place with 23 of the 27 elementary schools participating, but not all of those at a full level of participation. That system has approved, at the Board of Education level, sufficient funds to bring all 27 elementary schools up to a level of full participation, with all teachers trained, by September, 1983. This achievement depends on final approval of the Board of Education's request to the county commissioners for funding.

In two of the three counties the Board of Education have formally adopted the project. In the third county, the Board has formally accepted the program's goals and objectives, but has withheld formal approval of the materials. The latter is in accord with Board policy to approve materials only as a budget item and not as a facet of program approval. In all three cases the program meets the Maryland State Department mandate for a health education program.

In two counties 100% of the schools are participating and 100% of the students are being served through the health curriculum. In the third county school participation is at the 90% level and student participation is at the 50% level. This county anticipates participation to be at the 100% level, for both schools and students, in September, 1983. These information are provided in Table 1.

TABLE 1

Number of Schools and Pupils Participating in Primary Grades Health Curriculum--March, 1983

County	Total Elem. Schools in System	Total Elem. Schools Participating	Total Student Enrollment	Total Students Participating
1	13	13	2,462	2,462
2	22	22	3,247	3,247
3	27	24	4,783	2,330

School Health Project

Implementation of The School Health Curriculum Project has not met with the same level of success as has the Primary Grades Project. Only one of the three school systems indicated that the program was fully in place throughout the system with all schools participating. The other two systems reported that the Berkeley Project was "barely in place with only a few schools (25% or less) participating" as of March, 1983. In one of these systems there is little hope that the program will be resurrected due to the shortage of funds to "purchase materials and to train staff." In one of these systems there is however a strong commitment to develop a health curriculum for grades 4 and 5 during the Summer of 1983. Provision will be made for training all teachers in these grade levels in a program which will be based on the "best of Berkeley."

Two of the systems indicated that their boards of education have formally adopted the program. The third system reported that the board of education had not moved to formally adopt the program and that the program, though operating to some extent in two elementary schools, was no longer a County program. Only the system that has achieved "full implementation" indicated that their program puts them in compliance with the State mandate for a health education program.

The quantitative data for the implementation in grades underscore the limited success that two of the systems have experienced in implementing and maintaining this curriculum on a systemwide basis. Only the system that reported "full implementation" reflected a 100% participation level for all schools and students at these grades levels. One of the systems indicated that at one time the Berkeley program was fully in place and that it involved all students in grades 5, 6, and 7. That system now reports that only two elemen-

tary schools are offering the program; one to pupils in grade 4 and the other to pupils in grades 4 and 5. The third system indicates that parts of the program are operating in four schools and that activities in those schools are restricted to "the few basic materials that they have available in their schools." Data reflecting these levels of implementation are provided in Table 2 below.

Table 2

Schools and Pupils Participating in
the School Health Project (Grades 4-7), March, 1983

County	Total Schools in System Survey Grades 4 - 7	Total Schools Participating in Program	Total Enrollment in These Schools	Total Students Participating
1	13	2	2,462	96
2	27	27	3,747	3,747
3	29	4	2,632 (Grades 4-5)	250

Materials Control and Distribution

One class of problems that program managers reported were those in the areas of material shortages, scheduling difficulties, related to material shortages, and staff training requirements related to material usage and development. Material shortages sometimes occurred because of difficulty in locating a reliable supplier (this problem has lessened somewhat) and the resultant shortage of materials made for scheduling problems. Materials inventories and distribution also required considerable time on the part of the program's clerical staff and teachers. These problems seem to have been resolved to a great extent, but the time requirements on clerical staff can still be heavy at time. Staff training becomes a problem as teachers are reassigned from areas in which they have received training to areas where they have little or no training. For example, a primary grade teacher might be shifted to a grade level where the Berkeley materials are in use and have no prior training in their use.

All these school systems reported some concerns about materials costs and their replacement. One system indicated that it is currently not a problem, but could easily become one if the educational budget continues to contract as the current economic resession (somewhat worse in this area than other regions of the State) worsens. The other two systems reported present as well as future concerns in this area. One system indicates that it will require an additional $100,000 for materials in order to fully implement the program for its 7,000 elementary student population. The remaining system expressed concern over the "expensive" nature of some materials and that even when funds are available, replacement materials are not always easy to locate.

Materials inventory and distribution has been a problem in two of the three systems. In these systems materials need to be shared, sometimes between

two and three schools, and this makes for instructional problems when complete kits are not transferred either due to missing or broken items. This process of materials transfer requires close inventory controls at both the sending and receiving schools. While the systems have designed management strategies to deal with these problems, they still require a lot of time and energy. The real solution is more kits so less sharing is necessary and so that teachers have more flexibility in scheduling instruction.

Materials control is well provided for in all school systems in that responsibility has been clearly established at all levels. At the system level the person(s) responsible for materials control is the person responsibile for all aspects of the health program. At the school level, responsibility either rests with the principal, the media specialist, or both. The classroom teacher bears responsibility at that level.

Two of the three systems indicate that they have instituted materials control procedures beyond those normally used in the system. In both cases materials are shared by several schools and the inventory, maintenance and cross-checking procedures for health kits are carefully worked out and adhered to in order to assure every teacher equal access to the materials.

All three systems reflect a more intense materials control and supply problem in terms of the Berkeley materials than for the Primary Grades. In two systems the problem was critical enough to threaten the program's existence.

Several things tend to account for this fact. The Berkeley materials are more of the commercial variety and in a number of cases quite expensive. Also, they do not lend themselves to local development as readily as do the Primary Grades materials. They also require animal organs which necessitate special arrangements and timing. In some cases these organs are free, but in other cases they are sold commercially and must be paid for by the school or system.

The Berkeley Project was the first to be implemented in the three systems; Primary Grades implementation was at least three years later. It was therefore the implementation effort on which "learning" by trial and error was about the only alternative available. Management of materials was not as well planned for as it was for the Primary Grades materials. Where materials management was given due consideration in the planning for implementation, materials loss and misplacement was not as serious a problem.

Through experience, the systems discovered the need to assign specific responsibility for materials control and all found it necessary to allocate a large part of one clerical staff's work day to this task.

Personnel Development

The overall plan for implementation of Primary Grades and Berkeley Projects called for training and development for all classroom teachers, all building level administrators, all central office personnel, and all community leaders (such as health officers) who were to work directly with the programs. Therefore a section of the instrument for gathering data on project implementation devoted several questions to this activity.

Only one of the three systems reported that all principals and classroom teachers were trained for implementation of both the Primary Grades and Berkeley Programs. In that system training for some teachers consisted of "on the job" preparation by the "lead" teacher of the team.

The remaining two systems indicated that training was only partially achieved for classroom teachers and principals. They reported that this was true for both the Primary Grades and Berkeley programs. Principals appear to have received little or no preparation in a number of cases in both systems. One system reported a number of teachers could not be trained due to scheduling conflicts. In some cases, principals selectively attended training sessions and therefore missed parts of the orientation effort. Table 3 reports the system by system response on this activity.

TABLE 3

Principal and Teacher Participation
in Training and Orientation Sessions

County	Did all Principals Participate in Training and Orientation?		Did all Teachers Participate in Training and Orientation?	
	Primary Grades	Berkeley	Primary Grades	Berkeley
1	No	No	No	No
2	No	No	No	No
3	Yes	Yes	Yes	Yes

Reasons given for the failure of individuals to receive training included indifference, schedule conflicts, and perhaps a hope that failure to receive training would disqualify the individual from program participation. Personal interview information tends to support the feeling that a number of individuals, principals in particular, attached too little importance to the necessity for training in order to assure a quality effort.

All systems reported that training and orientation for teachers was often negated due to resignations, reductions in force, and reassignments. These three forces tended to cause questions to be raised about the efficacy of training (in fact the need for it) since a number of "trained" teachers were replaced by untrained or trained teachers were assigned outside the area of their training.

Respondents described the quality and thoroughness of the training program for teachers as being from "excellent in every respect" to "good, but could have been improved." The major concern expressed by those who saw room for improvement was the need to provide subsequent training after implementation. The proposed focus for these subsequent sessions was to examine new health knowledge and to develop awareness and understanding of revised curriculum guides.

The response to the quality of the training for principals was less positive for both the Primary Grades and Berkeley sessions. In only one instance did either of the programs receive an excellent rating. In three cases they were seen as being "good with room for improvement" and in two cases they were judged to be "inadequate for implementation needs." The major criticism of the principals' sessions were that they did not deal with the principal's management and supervisory problems and focused entirely on teacher concerns. It was also felt that a follow-up session for principals and

supervisors was very necessary. The fact that some principals attended few, if any, of these sessions also caused respondents to view the training program as inadequate. The responses to this item are presented in Table 4.

TABLE 4

Perceptions of the Quality of Training and Orientation for Teachers and Principals

County	Quality of Teacher Preparation		Quality of Principal Preparation	
	Primary Grades	Berkeley	Primary Grades	Berkeley
1	Excellent	Excellent	Excellent	Good
2	Excellent	Excellent	Inadequate*	Inadequate*
3	Good	Good	Good	Good

*Principals not trained.

Project Leadership

A significant finding in the research literature relates to the crucial role that leadership (commitment and involvement of key personnel) plays in the success of innovative efforts. In view of the importance attached to leadership, several questions were framed to determine the quality of leadership during the implementation effort. One set of questions dealt with leadership at the central office level and another set dealt with leadership at the school level.

One question asked the respondents to describe project leadership at the central office level in terms of the commitment and involvement of key personnel in project activities. The responses to this item were very similar for both the Primary Grades and Berkeley projects. All three systems reported that leadership at the central office level was from "good to excellent" with respect to the Primary Grades Project. The response to the leadership provided by central office to the Berkeley Project was also "good to excellent" except that in one system central office leadership changed at the end of the project's second year and from that time until the project was discontinued in 1981-82 there was little commitment or involvement expressed by the person assigned management responsibility. During that four year period project leadership was assigned to an individual in the system who felt it was not in harmony with his other duties and that he had insufficient time to perform the necessary leadership functions. Data reflecting leadership in the three systems are provided in Table 5.

TABLE 5

Quality of Project Leadership
at Central Office Level

County	Primary Grades	Berkeley Project
1	Excellent	Excellent (1975-77)* Fair (1977-81)
2	Excellent	Excellent
3	Good	Good

*Person had full time assignment

All respondents felt that project leadership was a significant determinant of project success. This response did not vary for either the Primary Grades or Berkeley projects. One system pointed out that under excellent leadership the Berkeley project flourished and grew, but that when a leader was assigned who did not see this as an activity to which he had even a modest level of commitment, the project died. In another instance a respondent cited the need to allocate at least 40% of one person's supervisory load to the project leadership function. The third respondent cautioned against assigning too many other responsibilities to the individual charged with project leadership and of the need to clearly establish and define management responsibilities.

For the most part project leadership was assigned to a central office person with responsibility for health education or for elementary education. In one system the elementary supervisor was later elevated to director of elementary education. In that system, the initial lead person was a coordinator, hired with project money, who had no specific system connection. This arrangement appeared to work out during that person's tenure, but the program fell apart at transition of responsibility. There is considerable experience with externally funded projects that suggests that externals hired to direct them are less effective in achieving systemwide integration than are individuals

who are from within the system.

The person who succeeded the initial coordinator had a secondary orientation and relatively little commitment to and involvement in elementary education prior to appointment, even though his assignment was K-12. It was no great surprize that this disposition resulted in little if any deep commitment to an elementary oriented health program.

The individual who succeeded to that position upon the retirement of the second supervisor, evidences a high level of commitment and is intensely involved in the Primary Grades program. This appears to have sparked program activity and a renewed vigor envelopes its activities.

Project leadership at the school level was not given the same high marks as it was at the central office level. In the Primary Grades program leadership at this level was described as being from "Excellent" to "Fair." In the case of the Berkeley program the ratings were from "Good" to "Fair."

Two conditions probably promoted these results. The critical factor was no doubt the failure of principals to participate fully in the training program. The other factor was that of time. In some cases principals had part time teaching assignments which lessened the time available for supervisory and leadership functions.

The inability of principals to take a full leadership role is reflected in the fact that in one system classroom teachers were seen as the sole providers of leadership at the school level. In a second system teachers and principals were seen as sharing the leadership role. These results were consistent for the Primary Grades and Berkeley programs. See Table 6 for a summary of results.

All respondents concurred that leadership at the school level was critical to project success. An important leadership role that principals

played was in the area of developing a team approach to program implementation. These skills were seen as resulting from the training sessions. Obviously those principals who failed to participate in training had little or no opportunity to develop these skills.

TABLE 6

Quality and Source of Project Leadership at School Level

County	Quality of Leadership Provided		Source of Leadership	
	Primary Grades	Berkeley	Primary Grades	Berkeley
1	Excellent	Good	Principal	Principal
2	Fair	Fair	Teachers	Teachers
3	Good	Good	Principals/ Teachers	Principals/ Teachers

Program Maintenance

Program maintenance was defined as those activities essential to keeping the project on target once implementation had been achieved, and/or after external funding for project activities had been exhausted. Again, prior experience had shown that projects initiated with external funds frequently become too much of a drain on local resources and tend not to survive; or manage to survive only in a reduced state. Survey questions were designed to test program viability once implementation had been achieved and external fiscal support had been withdrawn.

Two of the three counties indicated that project maintenance has placed a strain on system resources. They both indicated that top management attaches high priority to the health program (in one case priority is restricted to the Primary Grades program as Berkeley is no longer a county-wide program) and that funding has been available each fiscal year for program maintenance in spite of an overall decline in funding systemwide. The other system has reached a level of .50 implementation in the Primary Grades program and will continue Berkeley on a reduced basis. These conditions no doubt make maintenance (as we defined it) less of a current concern in that county as it is still undergoing a considerable implementation effort.

All systems viewed continued board of education support as essential to program maintenance. They indicated that administrative staff support was high, but that without continued fiscal support from the board of education the program will be in difficulty.

All systems reported that the responsibility for maintaining the community contacts and involvement essential to continued board of education support rests with either the project supervisor or with classroom teachers. Teachers perform an important function in this area in that they directly involve community

leaders and parents through the instructional activities. There was no evidence of systematic systemwide projects to keep the program in the public limelight. In the early stages of implementation there appears to have been an active public relations efforts that resulted in periodic press and radio releases, as well as some television coverage, but this is no longer happening to the same degree.

Continued teacher interest in and support for the program seems better assured. Teachers are benefitting directly from the program in terms of increased opportunities for additional training at no cost to them and, in some cases, with reimbursement. They are also experiencing opportunities to serve as resource persons in other classrooms and schools and to exhibit the products of their health classes at science fairs, PTA meetings, and other civic functions. These opportunities provide both student and teacher recognition and do much to engender continued parent and community support.

Another perserved pay-off to teachers was the fact that the program helps them to meet certain State mandates in the areas of health and basic education. Administrators need to verbalize these facts to their boards of education as boards make budget decisions which affect the program's future.

None of the systems are experiencing any problem in maintaining pupil interest and motivation for the program. All indicate that pupil interest remains very high (as we observed during our site visits) and that health has become the favorite subject for a large number of students. (We were impressed with the level of student excitement and enthusiasm in both the Primary Grades and Berkeley programs and comment on this in the section on site visitation.)

Systems indicate that in an effort to assure continuing student interest they have conducted curriculum revisions in order to eliminate duplications that existed between the Primary Grades and Berkeley programs. They also

indicated that students have received awards for outstanding health projects and that periodic visits to the classroom by the superintendents and director/supervisors of elementary education, as well as visits from individuals interested in learning about the program, serve to stimulate both teacher and student interests.

The active nature of the program, the opportunity to engage in problem solving provided through the instructional models used in the program, and the fact that the program materials and activities make the health lessons so directly personal for each learner all serve to keep student interest and motivation high. When one is expressing concern over materials costs, he/she must keep in mind that much of the student learning and a lot of the transfer of classroom learning to personal habits and attitudes about health go back to the reality provided by the rich materials used in the program.

Community Resources

From the outset, curriculum developers saw the need and advantages of developing the school health curriculum so as to promote widespread community involvement and interest in the hope that this action would provide a base of support for the students' educational program in their homes and in the broader community. Several aspects of the curriculum foster community involvement. The program is so structured as to necessitate an infustion of material resources from the community to carry out program activities. This is particularly the case in the Berkeley program. Also, the instructional approach--actively oriented and requiring a lot of adult assistance--fosters community involvement. Finally, a number of the units focus on the community agencies charged with health promotion and health care. These units provide opportunities to involve health leaders from both the private and public areas of health care and promotion.

A number of questions were structured to determine ways in which the schools and school systems used the resources of the community as they went about the task of program implementation. Questions were also raised in terms of their perception of the importance of the availability and use of community resources.

Two of the three systems expressed the belief that the availability and use of community resources was a factor in determining program success in both the Primary Grades and Berkeley programs. The remaining system responded in the negative to their being a factor in the success of either program. Those who commented on this item indicated that the role played by the County Health Department was outstanding and that the Department was providing resources to the programs.

In two of the three systems nurses from the County Health Department participated in the training sessions and in the other system the respondent was uncertain as to what the nurses role had been in the area of training. A check with the person who was responsible for the program from 1975-77 did not help to clarify the issue, but others in the system (classroom teachers) recalled their involvement. Apparently, in at least one system, community agency personnel other than the health nurses were involved in the training sessions held by teachers.

All three systems made widespread use of a number of agencies and individuals during implementation. They used local agencies and business (especially slaughter houses) as a source of materials for classroom activities. In many cases these were provided by the business or agency without or below cost. Agencies seen as important to implementation included the following examples:

American Cancer Society
American Heart Association
American Lung Association
American Red Cross
County Health Department
County and Community Rescue Agencies
Dental Society
Fire Departments
Local Colleges and Community Colleges
Local Hospitals
Local Businesses
Parents and private citizens
Private physicians and dentists
National Dairy Council

These lists and the various comments provided to the questions raised in the survey instrument indicate a relatively high level of community and agency support for project implementation. Parents and private citizens contributed many hours to program implementation at the classroom level and were instrumental in the area of materials development.

Personnel Preparation

Management's perception of how preparation took place and what their judgment as to its effectiveness was dealt with earlier. This section deals with the site visitation team's inquiries into this subject. It includes data related to their observations and interviews in situations where teachers and principals received little or no training.

In essence our site evaluations tended to produce a picture of training which was a little less bright than we had hoped might be the case. We observed and interviewed far too many people who had received little or no training and/or who had been trained in situations or under conditions which were less than desirable.

The failure of a number of principals to receive adequate training and their seeming indifference to the programs and to the teachers' problems was without questions the biggest disappointment we experienced during our three day site visit. The fact that those principals who had been trained responded much more knowledgeably and that they were much more involved in the instructional program points out the grieveous error of permitting any school to initiate a program without a trained principal and a trained teaching staff.

The problem with teacher training was three-fold. A number had not been trained except by other teachers--usually the lead teacher--on the team. This was less than satisfactory, but, for the most part, these teachers were trying and a number were succeeding. A second problem was that a number of teachers had been reassigned to an area different from the one for which they had been trained. This doesn't seem important on the surface, but to the teachers it was seen as critical. Several teachers indicated that the time pressures on getting through a unit didn't allow time for familarizing one's self with new content, new material, and new activities. We left very convinced that their's

was the correct view. A third concern that teachers expressed about the training was for a longer training program with more emphasis on program content. Teachers reflected that the content of the curriculum required a deeper and richer understanding of how the body works than they could recall from their high school and college programs.

The teachers saw a need for follow-up training. For many it has been six to nine years since they were initially trained. These has been more progress in health content during that time and teachers are feeling a need for more preparation.

They also see a need for summer workshops to refine curriculum goals and activities and to develop materials. Several commanted on the need to eliminate unnecessary duplication. Others saw a need to revise and shorten units; to lighten up on the number of objectives and activities. A number felt that new materials were needed in a number of areas, especially nutrition. Some of the work-sheets and dittos need to be reworked.

We were proud of the suggestions and comments that came from teachers. It was evident through our site visits why some program directors felt that a larger measure of program leadership was coming from the classroom.

Community Involvement

The way in which parents and other community leaders were involved in and utilized in the instructional program was discussed, at least in part, under instructional strategies. This section deals with observational and interview data collected by the visitation team which related to the use of community resources beyond that already presented.

A major use of community resources was in the area of supplies and materials and, to a much more limited degree, in materials development. The community served as a major resource for animal organs used in the classroom demonstrations and a number of the community health and safety oriented organizations made available free instructional materials.

In some cases parent volunteers and aides helped to develop materials for stations and in some instances they either purchased or brought from home items needed for their stations activities. However, for the most part, teachers developed their own materials and purchased, with their own money, station consumables.

In the early stages of program implementation there was an active program of community participation, including displays and exhibits at fairs, civic meetings, and PTA functions. Recently this type of activity has fallen off considerably, as has the number of press releases and "TV spots."

PART III

EVALUATION PROCEDURES

Descriptive Data on Project Operations in Allegany, Garrett and Washington Counties

Data on the three counties were gathered through the administration of a nine-page questionnaire which was completed by the program supervisor. One copy of the questionnaire was completed by each supervisor for the Primary Grades Health Curriculum (K-3) and a second copy of the same questionnaire was completed for The School Health Curriculum Project (Grades 4-7).

Mrs. Mary Malamphy, Supervisor for Elementary Education, and person directly responsible for program implementation, completed the forms for the Allegany County Public Schools.

In Garrett County, the forms were completed by Mrs. Charleen Evans-Thomas, Director of Elementary Education. Mrs. Thomas bears full responsibility for program implementation, having been assigned that responsibility over the past two years.

Mr. William Ford completed the forms for Washington County Schools. Mr. Ford, Elementary Supervisor for Washington County Schools, assumed responsibility for program operations at the beginning of the current school term.

These three individuals provided data on six different aspects of both the "Primary Grades Program" model and the "School Health Program" model. Each of the areas for which data were supplied is addressed in this section of the report. .These discussion are followed by a summary review of the more important data.

Evaluation Design and Procedures

Introduction

The evaluation was designed in accord with the principles and procedures adopted by the RESA Board of Directors as set forth in A Guide For Evaluating ARC Education Projects (September, 1981). The underlying principle of this document was that evaluation efforts be designed to assist project staffs and funding agencies to both judge and improve the worth of an educational project. Essential to that end was the requirement to include and involve appropriate project personnel in the evaluation effort in such a way as to effectively utilize their project knowledge and at the same time inform them on a continuing basis of evaluation findings and conclusions, without compromising the objectivity or the accuracy of the report.

The evaluation design called for a team approach. The evaluation team was involved in all aspects of the evaluation - from design to the writing of the final report--as were key project members of the three school systems in which the evaluations were conducted. Members of the evaluation team were all experienced in the evaluation process and several had the beneficial experience of having served on earlier performance review teams. The team members and a brief statement of their educational experiences follows:

Ms. Carol Bittner, assistant principal for Ridgeley Primary/Middle School, Ridgeley, West Virginia. Ms. Bittner has served in several capacities as a consultant/advisor to RESA activities,

Dr. Thomas Palardy, associate professor of elementary education, Frostburg State College, Frostburg, Maryland. Professor Palardy served on an earlier review team that evaluated the Primary Grades Health Curriculm Project.

Mrs. Maureen Palardy, assistant professor of early childhood education, Frostburg Frostburg State College, Frostburg, Maryland. She also served as a member of the evaluation team that conducted a performance review of the Primary Grades Curriculum Project.

Dr. Lewis Patterson, Evaluation Specialist, Regional Education Service Agency, Cumberland, Maryland. Dr. Patterson has had extensive experience in the area of his specialization.

Dr. James Dudley, Director for the University of Maryland's Center for Educational Research and Development. Dr. Dudley served as chairperson for the evaluation team. He has conducted numerous evaluation studies at the national, state, regional and local levels. He recently conducted nine evaluative studies of ARC funded projects for RESA.

Evaluation Approach

Members of the evaluation team met in three separate planning sessions to establish the evaluation design. The sessions were devoted to sharpening the evaluation questions, developing and refining the data collection instruments and interview procedures, and for establishing a time table for the site visitations. These sessions were attended by the supervisor for each local school system, and by representatives from the Health Systems Agency of Western Maryland. and the Executive Director for RESA.

Each of the supervisors for the health education program in their respective school systems made detailed arrangements for the site visits to that school system. One full day was given to each visit. Each visitation was preceded by a one-to two -hour team orientation session during which time the local supervisor discussed the planned visitation schedule and established expectations and rules for each segment of the schedule. During the course of each day the team met with the Central Office staff; visited from three to four schools; met with building principals, classroom teachers, students and community leaders; and conducted a summary session with the local supervisor present. (The visitation schedules for the three site visits are provided in Appendix A.)

Data Collection Procedures

Two separate instruments were designed for data collection purposes. The Health Curriculum Project Evaluation Form I was completed by the local project supervisor with the assistance of other local personnel as needed. For II was designed for use by members of the evaluation team at the time of the site visit. (Copies of Form I and Form II are provided in Appendix B.)

Form I was a nine page instrument with six separate sections or parts. It was designed to gather descriptive data about the project's current status; significant implementation steps and procedures; project maintenance efforts and activities; noteworthy project adaptations; noteworthy project accomplishments; and plans for the improvement of the project over the next five years.

This form was completed in each case by the local school system person charged with overall supervisory responsibility for program activities. Each supervisor completed two copies of the form--one for the primary grades or Seattle Model and one for grades 4-7 or the Berkeley model. Data from these instruments were shared with evaluation team members prior to each site visit.

Form II was designed for use by members of the evaluation team during the site visitation. It provided for a combination of interview and observational data. It was anticipated that each team member would complete one copy of this five-page form at each of the sites visited; about four instruments per team member for each of the three days devoted to site visits. It was not expected that all portions of either the interview schedule and/or observational schedule would be completed at each of the "stops" as questions were not necessarily appropriate at every level or for every position being interviewed.

This instrument was designed in such a way as to provide some cross validation of the data obtained on Form I, as well as to obtain new data on project operations. Part I was used to gather interview data from central

office personnel, school principals, classroom teachers, students, and community leaders and parents involved in program operations. It consists of four separate sections, each dealing with different aspects of the interviewee's perceptions of the way in which the program operated, the training and support provided, the quality of program management, concerns and expectations for the program's future, and noteworthy aspects of program results.

Part II of Form II was structured to gather observational data on each site visited. Team members were expected to complete this section as they observed in classrooms, walked through the building, or sat in on group meetings. The form provided space for informational entries on such areas as management, leadership; personnel preparation, pupil responsiveness, community involvement, and noteworthy achievements. While team members found this form a little difficult to follow and some preferred a less structured approach to data gathering on site, over fifty of these forms were completed (in full or in part) during the three days of site visits. Team members were responsible for summarizing all data collected at the end of each day of visitation and for sharing highlights of their summaries during the follow-up session that concluded each day of visitation. These data summaries and the completed forms for that site visit were then handed or mailed to the team chairperson for use in assembling the final report.

In combination, Form I and Form II yielded over 300 pages of data that had to be analyzed and synthesized for this report. Form I data are presented in the report section entitled "Descriptive Data on Project Operations" and Form II data are presented in the section entitled "Site Visitation Data". The findings, conclusion and recommendations drawn from both sets of data are presented in a separate section of the report.

Site Visitation Data

Introduction

A five-member visitation team spent one full day in each of the three school systems for the purpose of observing program activities and for interviewing project staff. Each visitation was preceded by a one to two-hour orientation session with the project director for that site making for a total of approximately ten hours for each site visit, or about 150 man hours of visitation time for the three days. In addition each member spent an hour or more developing summaries of the visitation data gathered during the day.

The site visitation team focused on a number of items:

1. Was the program what it claimed to be? The program is stated to be a comprehensive health curriculum program to help children learn more about themselves by learning how their bodies work with an aim to providing students with information to help them remain healthy throughout their lives. We sought an answer, through observation and through interview procedures, to determine whether or not children were receiving a comprehensive program and was it seeming to have an impact on the way they thought and behaved with respect to their bodies.

2. How was the program organized for instruction? It was also stated that each grade focused on a health-related unit for ten weeks and that each unit is taught through seven phases. In the Primary Grades (K-3) concentration was to be on the five senses while the School Health Curriculum Project: Berkeley Model (Grades 4-7) was to present the different body systems (exclusive of the reproductive system). We observed and asked questions to determine whether or not the phases were being implemented; whether sessions were for 10 weeks, whether or not content was being taught at the appropriate levels.

3. How does the program work? The program claims to use a hands on approach--children learning by doing--with the Learning Center approach and community resource people central to that approach. The project claims to provide the opportunity to explore, to share, to create and in the process to develop positive feelings about self. The site visitation team observed and asked questions intended to reveal the extent to which the program was actively oriented; the degree to which children had hands-on experience; and whether there were opportunities for explaining, for sharing, and for creating. We wanted to know how children were responding to the program; what were their feelings about self and others.

We wanted to know if the goals and objectives of the two curricula were being taught and were children seeming to acquire this knowledge. We interviewed principals, teachers, and students to get our answers to these questions.

4. What were the efforts to prepare personnel for the project? The project implementation plans and the project director's reports all addressed the need for staff training. We interviewed staff to determine whether they received training? If so, how much and how effective was it? What else needs to be done to insure continued teacher competence and commitment?

5. How did implementation efforts involve and make use of community resources? Fundamental to the two projects is the assertion that community involvement is crucial to project success. Therefore, we wanted to ascertain, through our visits, whether there was evidence relative to the involvement of parents and community leaders.

6. What were the projects noteworthy adaptations and achievements? It seemed important to the dissemination effort to discuss any program adaptations that were made which could have implications for further dissemination. It also seemed important to observe and record important achievements.

7. What are the projects' future prospects? A large number of externally funded projects have been well received so long as funding continued, but quickly put aside when system resources had to bear the load. Our interests in this project was to determine whether or not a similar fate was in store for this project. Therefore we raised questions about management and board commitment; about fiscal resource availability; about continued teacher and student enthusiasm.

These seven questions formed the basis for our observations and interviews. The answers to these questions should help to confirm or refute the stated intentions of the project and they would do much to test the validity of the reports filed by the project directors. They are, we feel the kinds of questions that others considering implementation of the project would want answers to.

They also serve to organize the data for this report. Each question is addressed in the seven following sections. These are followed by a brief summary.

PART IV

FINDINGS

Introduction

The first part of this section of the report contains findings and conclusions. Findings are separated into several categories with overall findings addressed first. The final part of this section deals with recommendations. Recommendations are of two types. One type of recommendation is aimed at improving program quality in the three school systems that were involved in the evaluation effort. The second type is aimed at assisting future dissemination efforts.

Overall Findings

The essential finding of this evaluation study was that the attempt to implement a holistic health curriculum in the three school systems of Western Maryland--Allegany, Garrett, and Washington Counties--utilizing the Primary Grades Health Curriculum Project (Seattle Model) and the School Health Curriculum Project (Berkeley Model), has been fully successful in one of the three systems and partially successful in the other two. It was a further finding that efforts to implement the Primary Grades (K-3) curriculum has succeeded, for the most part, in the remaining two systems, and that the School Health Curriculum Project, Berkeley Model (grades 4-7) has been withdrawn as an all-County program in one system and is surviving in part in the second. That system contemplates an effort to restructure this project during the Summer, 1983 by putting the "Best of Berkeley" in grades 4 and 5. Based on these and related findings we feel the program is ready for further dissemination.

In was the conclusion of the evaluation team that multi-factors contributed to the downfall of the program in grades 4-7 in the two systems and that, to varying degrees, these same forces continue to threaten the survival of the program in all three counties. Factors determined to have been instrumental

to the breakdown in implementation efforts relate largely to failure on the part of project management to fully grasp the enormity of the effort required and to plan accordingly. Instability in the leadership function at the central office level and seemingly indifference on the part of managers and leaders at the school level played no small role in bringing about this failure. A tightening of the fiscal conditions in these systems, due largely to a worsening economy, was only important to the extent that it did not permit the system to use money as a substitute for good management and committed leadership.

The evaluation effort indicates, in our opinion, that the forces that brought about the downfall of the health curriculum in grades 4-7 still haunt the programs and could possibly bring the primary grades project to a halt in one of the counties and hinder further program development in the other two. While all three systems presently possess excellent and highly committed leaders at the central office level, these individuals will require the full support and participation of their supervisors if they are to overcome the problems that challenge the program they lead.

The most significant problems the programs now face are acute shortages in the area of materials, training, and leadership at the school level.

We found a wide variance in management competency and commitment at the school level. A number of principals had not been adequately prepared for their managerial and leadership roles and project leadership in those schools resided with the classroom teachers.

There are acute materials shortages throughout the program; Primary Grades and Berkeley. These shortages result in next to impossible conditions at the classroom level. Project leaders are trying desparately to stretch materials through excellent scheduling and inventory control procedures, but these devices are seen as incumbrances on the part of classroom teachers and thus tend to undermine the authority and influence of the project leaders.

Present levels of training and preparation are inadequate for both teachers and principals. Teachers have "outgrown" the training they received and thirst for new training activities. Principals, in some cases, were never adequately prepared for their roles and must be trained properly, if the management and leadership situation is to improve at the school level.

Specific Findings

Specific findings are separated into several categories. In some cases they tend to repeat portions of the overall findings but it is hoped that their fuller treatment in this section will be helpful to those who read and use this report.

Management Considerations

The essential finding in this area was that overall program management was not as well defined and specified as it needs to be for an innovative effort. There is little evidence that specific management plans were developed which setforth project management goals and objectives, management activities essential to the achievement of those goals and objectives, and specific statements of assigned responsibility at both the central office and school levels. The resultant strategy was to depend heavily upon traditional management procedures and roles to carry the implementation effort. Unfortunately, these are seldom sufficient to the introduction of a new program.

Management changes occurred in the two programs that experienced difficulty. Whether these changes were the cause or effect of prior program management is not known. We do know that one of the replaced managers was regarded as excellent by his superiors but we have little data on the others to report. Instability in the management function certainly did not enhance program chances. Now that management at the central office level is stable in all three systems, program management appears to be sound.

There is no indication that management responsibilities at the school level were properly addressed--traditional authority and responsibility were assumed sufficient to implementation needs. In several cases principals were not properly oriented and prepared for their management roles and as a consequence the burden of project management and leadership often shifted to

the classroom teacher. The result of all of this was indifferent management at the school level.

Strong management and committed leaders at the school level could have helped to offset the lapses that occurred at the central office levels. Caring managers at the school level could have safeguarded the valuable and costly equipment and seen that items were not lost, misplaced, or mistreated.

It is the conclusion of the evaluation team that faculty management was a major contributor to program breakdown and that some of these same conditions are still actively threatening the program's present and future chances for survival.

Leadership

We separate leadership from management as we defined it as commitment to and involvement in making the program succeed. We found the present project managers to be high in leadership in that they evidence a great deal of commitment to attinaing and maintaining program quality and in that they are very actively involved in project activities. This, unfortunately has not always been the case. It is the finding of this report that two of the three systems either lacked, or possessed in limited way, the kind of leadership essential to new program implementation during a large segment of the time while the Berkeley model was being implemented. It is our conclusion that this deficiency played a major role in the downfall of those two programs.

Our finding is that leadership at the school level has been and continues to be mixed. We evidenced some situations in which principals were providing high quality leadership, but this was too infrequent to assure overall program success. (And we suspect we observed in some of the better situations.)

In a number of cases leadership at the building level was being provided by teachers rather than principals as teachers were responsible for making their arrangements for community volunteers, consumable supplies, and similar activities.

It is our conclusion that leader deficiences at the building level pose a threat to the continued success of the Primary Grades Curriculum Project much in the same way that it was a major contributor to the downfall of the Berkeley program.

Materials Control and Distribution

Implementation efforts were accompanied by widespread problems in materials control and distribution in such a way that materials were lost, misplaced and/or mishandled. This condition brought about the collapse of the Berkeley program in one system and left it badly battered in a second.

Fortunately, this experience resulted in much better materials management for Primary Grades materials and it is our finding that materials are controlled and distributed in such a way to assure proper inventory and distribution. We applaude the present project leaders for their efforts in this area.

The existing problem with respect to materials has to do with their acute shortage and the fact that the materials control and distribution procedures sometimes weigh heavily on the classroom teachers. The shortage of materials tends to limit flexibility in scheduling and sometimes necessitates as many as three teachers sharing the same kit during a thirty to thirty-five minute health lesson.

It is therefore the conclusion of the review committee that systems need to reconsider the materials supply question if program quality and teacher support and enthusiasm is to remain high.

Classroom Instruction

It is the finding of this evaluation that teaching in the program, at least that which we had the pleasure to offer, is of very high quality. In some cases we observed teaching and classroom organization that was exemplary.

It is also our finding that the teaching strategies employed in the health curriculum have transferred to other areas, particularly science, and that their programs have gained from this fact.

We found a lot of teacher commitment to the program and we discovered numerous cases of leadership for program maintenance and improvement coming from the classrooms.

Those who had observed in this program before felt that they noticed a marked decline in the "spark and enthusiasm" being displayed by several of the teachers who had lead the pilot project. This seemed more noticeable in areas where teachers were trying to overcome deficiencies in the area of materials and administrative support.

It is our conclusion that teaching is excellent in the program and that this excellence is in itself a good reason for considering program adoption.

Student Response

It is our finding that the greatest program impact has been on the learners in the program. Everywhere we went, we witnessed a high level of student enthusiasm and support for the program. Our interviews with students provided some of the happiest moments of our site visits.

Students report that they feel the program has made a major difference in the way in which they view their own personal health and safety and the way in which they regard the health and safety of others. Invariably students indicated that health is their favorite subject. We sincerely doubt that this is the case for the same number of students anywhere else in the State.

It is our conclusion, based on these findings, that the program has had strong positive effects on the student population. So strong is this impact, that we feel forced to implore program managers to extend this program beyond the primary grades and intermediate grades (in that system where it still resides at that level) into the early years of the secondary school.

Adaptations and Additions

We found ample evidence, at the classroom level, that teachers are both capable and interested in adopting and/or making minor additions to the program so that it might better serve the needs of learners. We also heard plans for a major revision of the Berkeley program in order to create a best of Berkeley for grades 4 and 5.

We saw the need for curriculum revision, primarily to eliminate unnecessary duplication, and update at the systemwide level. Such revisions can lead to the development of tighter program units and materials development.

It is our conclusion that classroom teachers can and will make program adaptions to make the program more beneficial to students and to adjust the program to individual learner needs.

Future Prospects

We feel that this particular health curriculum represents the holistic health curriculum model that the three systems and RESA were striving to implement and that present implementation efforts indicate that the systems have, to some degree, had to progress through trial and error methods but that this has produced a highly valuable program worthy of maintenance and further development. Given the proper management and the necessary leadership and resource commitment, this program has excellent prospects for serving the health education needs of the pupils in these three counties for a number of years.

Community Interest and Support

It is our finding that there is widespread community interest in and support for this program. Both of our data searches support this finding. We saw parents functioning as aides and assistants to the primary grades teachers in a number of situations and there was strong evidence that this is ongoing. Unfortunately, we did not see the same level of parent involvement in the Berkeley.

The data indicate a strong effort to involve the community and to keep it involved in the early stages of program implementation. We did not find sufficient evidence to support the view that these efforts are continuing at the same level and we found little evidence that building level administrators are taking appropriate advantage of the opportunity to involve and inform their citizens.

It is our conclusion that community support and information sharing are much higher for the health curriculum than for other areas. We also conclude that this level will soon match that of the other programs if central office and building level leadership does not address this need more directly.

Noteworthy Adaptations and Achievements

We asked our respondents to share with us those aspects of their programs which they saw as noteworthy in that they resulted in improved quality and utility to and throughout the system. The question was raised with limited expectations since the systems have been concentrating on implementation, in some areas they still are, and have not had adequate time or opportunities to take a reflective look at their program in that sense. To our surprize, they provided numerous answers.

In the area of personnel development they offered two adaptations in system procedures. Teachers are increasingly used as resource people as a result of this program and this enlarged view of the teacher's potential has increased their own recognition levels and has provided the systems with an in-system resource for staff training and development. Also the fact that principals and teachers were thrown together for training is seen as an adaptation in personnel development. The fact that these experiences assisted principals in the area of team building and that they helped to foster teacher-principal relations were seen as positive outcomes that have affected other program areas as well. Some reported that management skills were enhanced in the areas of routing schedules, materials controls, and program management which have broad application for their work. Certainly the program brings to light the need for strong leadership, for a structured management plan, and for clerical support to the instructional process as well as to management activities. One of the systems indicated how it had affected the type of work that clerical personnel in the program were being assigned; work which theretofore had been reserved for professional managers.

Perhaps the greatest adaptation was in the area of materials--their development, their inventorying, and their distribution. The materials are critical to program development and they certainly have had an affect on both students and teachers in this program. This use of materials has carried over to other areas and science units have been developed utilizing the health program models.

The program has served to reinforce the need for leadership so that systems will be looking more closely at the need to provide training for principals. Systems have definite plans to pursue this activity during the Summer, 1983.

The program has rekindled community interest in and support for education. Parental and community involvement in this program has brought numerous people into contact with teachers and the classroom. These experiences have helped them to develop a renewed respect for education and a new perception of what the schools are doing to educate the young, not only in health but in other areas as well.

This has excited the schools and teachers to seek more opportunities to involve the community and, as reported earlier, has helped the systems to better visualize the teacher and student as their first line of public relations.

Among the most noteworthy achievements that have come about as a result of the curriculum improvement effort are the following:

-A number of parents have given up smoking!

-Classroom methodology has been improved!

-There has been a renewed interest in science and in experimentation, discovering, and problem solving.

-Teacher interest and motivation has been heightened.

-Parental support of and respect for teachers has increased!

-Students enjoy health education.

-Parent and community leaders have praised the program!

Noteworthy Adaptations and Achievements

We have previously dealt with this topic as an area of concern in the section on "Descriptive Project Data." This section is limited to what the evaluation team discovered during the on-site visits.

Initially there was some negative response on the part of team members regarding the "Best of Berkeley" concept. There was the fear that what was really being proposed was the "Rest of Berkeley," that is what could be pieced together from the remaining materials. We were pleasantly surprized to find out out that this is a well-conceived project to revive the "Berkeley Program"—at least for grades 4 and 5--and to thoroughly integrate it with the Primary Grades. The plan also calls for updating the Berkeley concepts and content to include developments in health which have occurred since "Berkeley" was developed. We also learned that this is to be done through a summer workshop that will involve teachers. This is an excellent adaptation and a needed forward step. The process and results of this effort need to be duly recorded and passed on to other systems. It well may be that a few of the teachers in the County that has abandoned Berkeley, with the exception of two schools, could profit from participation in this effort.

We observed a four member teacher team in action that had developed an exceptionally fine unit and which involved youngsters in a manner that was exemplary. This activity needs to be either "written" for publication or developed into a 10-15 minute film or slide-tape presentation for use in staff training and also for use in public relations. The unit has strong implications for dissemination.

We also observed "station work" in several classrooms that needs to be shared through either a film or slide-tape presentation. Also, we experienced some excellent "direct teaching" which is critical to providing proper balance in a program committed to a "learning stations approach."

Also, there are numerous management adaptations that need to be passed along to other systems. The systemwide schedules, though in need of revision unless the program is revised to reduce what has to be taught, are useful models. The systems for maintaining materials controls developed by each of the systems are excellent examples of management adaptations to cope with this particular problem.

The needed revision of curricula with an eye to eliminating duplication and "streamlining" requirements should be a valuable addition once it is completed. The revision of training experiences, especially for principals, and the development of new training areas for teachers, could be an invaluable achievement.

Instructional Organization

The two curricula provide for a highly structured instructional approach that makes use of:

-A ten week instructional period for each unit, with each unit separated into seven phases.

-The Primary Grades Program was to concentrate on the five senses and on how these senses affect the way in which we appreciate life. Some time is also given to feelings about self and the capacity to express and share these feelings.

-The School Health Curriculum Project: Berkeley Model (Grades 4-7) was to present the different body systems.

Our team observed and raised questions to determine the extent to which this organizational plan was incorporated into the program(s) that had implemented in the three school systems.

The fundamental answer to this question was positive. Central office and school leaders had combined efforts to establish a schedule of activities which assured rather close adherence to the proposed time constraints. We found evidence of such schedules in all three systems and sample schedules are provided in Appendix D. In addition some schools worked up additional schedules to compliment the system schedule. In spite of this advanced planning, we discovered (as noted above) that it was sometimes difficult for teachers to operate within these time frames and give adequate attention to each phase. As a consequence, daily instruction frequently went beyond the time specified for the subject.

In every instance we observed primary grade instruction (K-3) to be in the designated area. There was evidence of good to excellent use of materials and choice of activities and these were numerous charts, displays, and other visuals to provide evidence that the appropriate program content was being taught. We observed excellent use of a wide range of materials across the four grades of primary emphasis and excellent evidence that all phases of the unit were being covered.

The story for the intermediate grades (4-7) where the Berkeley model was in place (two systems had only a few schools in which Berkeley was still available) was very similar. The units on the systems of the body were definitely the focus of instruction and there was a wide range of classroom visuals to support instruction. Schedules for these grade levels were also available in the system where Berkeley was fully implemented.

Instructional Approaches Being Used

The evaluation team observed the program in a number of schools, sat in on lessons in a number of classrooms, and interviewed principals, teachers and students all for the purpose of determining whether the instructional approaches being used were those recommended in the program guides and manuals. We found for the most part that they were.

We saw many instances in which learning was organized around the stations approach. We saw a fine balance between teacher directed activity and small group work in which students were engaged in hands-on experience. There was a lot of exploring and a lot of sharing and more than a little evidence of creative activity. Often the teachers where assisted in this phase of instruction by parent volunteers and/or Chapter I aides.

We saw instruction taking place with a wide range of media and materials and we saw, in some instances, excellent use being made of the instructional kits. Unfortunately, we also observed teachers who were limited in offering instruction from such a wide and varied approach because they either lacked the materials, equipment or space. Some teachers, operating in conventional classrooms, were forced to use hall space for their stations until the fire marshal banned the practice as being dangerous to quick and easy escape in case of an emergency. Teachers in "open-space" buildings were less hampered by space restructions, but they still had to cope with materials and time problems.

The use of community personnel and other resources was somewhat mixed. In a number of cases we saw excellent use being made of parent volunteers and aides. We also observed community leaders serving as resource people (mostly as speakers). Whether or not there was wide use of parents depended to a large measure on the initiative of the classroom teachers. In a number of

instances teachers had little, if any, support from their principals in obtaining volunteers.

Parents and community leaders tended to be more visible in the Primary Grades than in the Berkeley program. Perhaps this was because we spent more time in the Primary Grades area than we did in the Berkeley.

We observed one of the finest approaches to instruction in a Berkeley unit that involved four teachers in a single team. During that period of instruction students were divided into teams and teams were subdivided into work groups. Teachers served as resource persons to the teams and work groups.

Teams rotated from one instructor to another as they focused on different aspects of the unit at hand. There was a wide range of materials and equipment present and each hands-on assignment had specific learning objectives, well defined student-directed activities, and each was self-checking with a teacher confirming mastery after completion of the stations and self-checks.

We also observed excellent "stations" work being done in the primary grades using parent volunteers to supervise stations. Students were engaged in experimentation and problem solving activities and were completing work sheets, recording their findings and observations.

We were very much impressed with student response to and enthusiasm for the program. Students were, in many cases, simply elated over learning something about their own bodies. In one instance an entire class broke out in spontaneous song; a song which related how the body functions as a super-machine. Numerous students indicated that health was their favorite school subject and that they felt they were learning a "lot of things" that would help them as they went through life.

We observed a mix of teacher response. For the most part teachers were very positive and supportive of the program. They reflected how the

instructional approaches being used seemed to help even the most limited students to become involved in meaningful learning. They praised the materials and expressed confidence in managements commitment and competence.

On the other hand, we saw some teachers not displaying the same spark and enthusiasm they displayed in an earlier performance review. Perhaps this was due to the fact that the program had lost some of its newness and had "settled in" to become a part of the total curriculum. At least one might reasonably expect this to happen as a program becomes more routine after several years of experience.

On several occasions we observed teachers struggling to make things go without the benefit of their immediate administrator's support. Several teachers expressed resentment over this seeming lack of administrative interest. Some of these omissions caused one member of the review team to raise a questions about what happened to the previous performance review and to wonder why its recommendations were not acted upon.

But whatever these shortcomings, we do not wish to leave the impression that these conditions were "the rule." In truth we saw more examples of excellent instruction, solid teaching, and strong objective well-balanced teachers working in these three systems than most critics of education would accept as being found in the total profession. And some of the "less than excellent" teaching we observed had earlier been observed as being excellent. This leads us to believe that some teachers have given up in the face of administrative indifference, materials shortages, space restrictions, and time constraints. But let it be understood, we observed no teacher who had given up on children.

PART V
CONCLUSIONS AND RECOMMENDATIONS

Conclusions

A major consideration of the evaluation team that conducted the site visitations was the extent to which the implemented program is indeed an integration of the two curricula models that were targetted for implementation. Therefore questions were raised and observations entered into which could determine whether or not the program was comprehensive in nature and sufficient in implementation to truly help children learn more about themselves by learning how their bodies work and whether or not there was any indicators that this knowledge was sufficient to lifetime habits and practices leading to good health.

There is no question whatsoever that what is operational in the schools and classrooms we visited is the program as put forth in the two curricula targetted for implementation. The program(s) we observed reflect a comprehensive approach to health education which focuses learner attention on self and which stresses the acquisition of health knowledge and attitudes which should have positive lifetime impact on personal health.

The question regarding whether or not it is resulting in tangible results is a little mixed--there were no doubtful responses to this item--but the majority response was that it has been a factor in reducing drug, alcohol and smoking experimentation; that it had made children more sensitive to actions which could produce injury to self and others; that it had made children more conscious of what they were eating (even affected the kinds of snacks parents serve); and that it helps children to express and share feelings about self.

There were problems in integrating the two curricula; some of which remain unsolved, but which are not insolvable. The major problem in fitting the two curricula together is in the area of duplication. While some duplication may be desirable and even serve as an opportunity to push deeper into the content

at the second or third offering, the overall feeling among teachers and principals was that some time needs to be devoted to curriculum refinement aimed at eliminating undesirable duplication. The spiral nature of the curricula is not as apparent at the operational level as it is considered to be in program materials. This issue needs to be addressed as curricula objectives and activities are refined.

Refinement is also needed to reduce the time demands. While the program suggests that the seven phases can be successfully negotiated in the alloted time, we found few teachers who would agree. Even teachers who have been working with the program for six to nine years are experiencing problems in teaching it within the scheduled time. Teachers newer to the program are sometimes overwhelmed by the time required to complete a unit.

Another difficulty that exists which requires some refinement has to do with unevenness in the level of difficulties within units and a similar problem with materials. Print materials are not always age-graded and reflect, in some cases, too wide a range of reading levels for primary grade children. Some are too difficult for even the brightest children.

These problems are, in the judgment of all we talked with, capable of being solved and need to be addressed in a summer workshop for curriculum revision.

The Berkeley program is somewhat dated at this time and needs considerable revision. One county has given consideration to the development of the "Best of Berkeley" for grades 4 and 5. The evaluation team applauds this commitment to reconstruct the Berkeley model in such a way as to better integrate it with the Primary Grades approach and to put into place a well-integrated curricula for grades K-5 so long as the revision of Berkeley is done by individuals who are also familar with the Primary Grades program.

Finally, there is need to approach program revision in terms of achieving a better match with State standards and to look for areas in which it does or can be altered to meet State requirements for Project Basic. This kind of curriculum match will do much to insure the health program solid attachment to the system's total program of studies and help to assure its survival over time. The team thinks that long term survival, for both the Primary Grades and Intermediate Grades (Berkeley) models, is highly questionable in one system and somewhat doubtful in the second. If the second system does not receive funding this summer for further program implementation (it has management and board support but needs confirmation by the commissioners), the program may not survive beyond the next two or three years.

Recommendations

The evaluation team offers the following recommendations for consideration by the three systems that we evaluated and for any and all systems contemplating adoption:

Widespread Dissemination. We recommended the widespread dissemination of the holistic health curriculum (the integrated Primary Grades and School Health Curriculum Projects) so long as implementing systems are committed to the management and resouce requirements that a successful implementation effort requires.

Formal Adoption. We strongly recommend that implementation decisions we formalized and that this statement of formal adoptions be circulated throughout the system. The adoption statement should spell out implementation procedures--role and responsibilities.

Community Involvement. Implementation plans must provide for widespread community involvement in project activities at all levels, from classroom to central office. This involvement must include agencies, organizations, and businesses as well as key individuals.

Public Information Program. Planning needs to include a systematic plan for keeping the community informed and knowledgeable about implementation efforts. It is important to keep the program highly visible in the community in fostering health knowledge and practice and in order to assure a continuing base of community support.

Systemside Instructional Improvement. We recommend the program to systems seeking strategies for systemwide instructional improvement based on the fact that the instructional strategies and approaches found in this program have application in other curricula areas.

Management Planning. Successful implementation requires effective management planning from the very outset. Broad or strategic planning should include representatives from all levels including classroom teachers and parents. Planning needs to be thorough in terms of implementation goals (objectives) and activities; detailed statements of whose responsible for each activity and who plays a supportive role to that activity. Provision for program evaluation needs to be an integral part of this planning activity. The plan should also indicate base line data to be collected for later evaluation use.

Leadership. Efforts must be extended by top management to assure that individuals in key roles (central office, principals, and teachers) have the necessary commitment to program success. Every effort must be extended to develop the leadership role of building level administration.

Materials. We recommend that no more than two teachers share a kit at a given instructional time. Where three or more teachers form a team, an extra kit needs to be available. We also recommend material control

and distribution procedures similar to those now in place in the three systems. We recommend clerical support for this effort up to .50 clerical lines per system, depending on size.

Training and Staff Development. Training and staff development are absolutely essential to successful implementation. No person working directly with the program should be excluded from these activities. Principals must be trained in all aspects of program management and implementation. There must also be provision for updating training at the end of three years of implementation effort.

Program Revision and Update. Planning must provide for periodic program revision and update. This activity can be easily and effectively integrated with subsequent staff training and development.

Learner Growth and Development. We observed ample evidence of learner growth and development. We recommend that systems document this growth (affective as well as cognitive) as a means of determining program success at the product level. We also recommend that these data be shared with the parents and community as to assure full understanding of and support for the program.

Adaptation. We recommend that planning provide for systematic examination of the program to determine where adaptation and refinement is needed.

Future Plans

The systems are already considering ways that can improve upon what they have. Plans to provide subsequent training for teachers and principals have been developed. Plans for development of new and better teaching materials are being drawn up. Programs will be updated to reflect new health knowledge and material placement will continue to occur.

The methods and approaches of the health curriculum will be adapted to other curricula areas, especially science, in hopes of creating the same kinds of success in that area. The Berkeley program will be adapted in one system so that the "best of Berkeley" will be put together into a single comprehensive curriculum for grade levels 4 and 5.

The school systems look forward to a time when resources will permit each school to have its own materials, so that there will be greater flexibility in both scheduling and teaching. Sharing of materials greatly restricts when and for what length of time teachers can work with a health unit.

The overall view of the future expressed by program leaders in one of optimism and hope. We heard and read only positive comments as we asked the question, "Where do we go grom here?" Nobody stated or even suggested that the journey had reached an end. Most were of the belief that it had really just begun!

Future Prospects

The needs that this program serves should assure its continuation even if one were not impressed with its quality and with the positive way in which students and parents have responded. However, the visitation team could and did envision the program as having a rather bleak future if certain things do not happen. A few of the things that must happen to assure program maintenance and growth are:

-Increased leadership, particularly at the building level.

-Continued improvement and commitment of management at the central office level.

-Improvement in the materials situation. More supplies, more complete kits, and less requirement for staff sharing of materials.

-Additional training for teachers and principals.

-Improved community relations and more leadership on the part of principals in the area of volunteer recruitment.

-Some solution to the space constraints in the traditional buildings.

-Increased public relations. More radio and press releases, more T.V. spots, and better utilization of the PTA in this role.

-More opportunity for teacher recognition. More support for teachers.

This is a relatively long list--it could be lengthened--and to implement some which require additional resources which the systems are finding it difficult to raise. Systems should at least do those things that are relatively cost free and look for alternate ways to achieve the others at a cost that the system can afford.

One thing that is unaffordable is indifference to these and other needs, if the programs future is to be as bright as its past and if the quality parts we saw are to become more commonplace throughout all three systems.

It needs to be noted that we saw little real or hard data on student achievement and changes in health behavior and attitudes. We heard a lot of

testimony, too much to pass it off as non-substantive and we saw and talked with students who evidenced a high regard for the program and who stated they were learning many valuable lessons. We also observed children actually enjoying the hard work of learning and there was the one survey that showed a decline in smoking and drug use among high school students who had the program at the elementary and intermediate levels. These are, in our opinion, hard and non-refutable evidence that the program has succeeded.

But skeptics will demand more, as would prudent management! Therefore, if the program is to have a bright future, there must be more systematic approaches to gathering "hard" evidences--facts and figures--relative to ways in which the program has changed health practices and attitudes. There must be more evidence that learners engaged in non-direct study indeed achieve mastery of program concepts, content, and skills and that it does change the way students approach the whole question of healthful living.

As we have tried to indicated throughout the report, we were impressed with much of what we saw. But the need to assure that others will be equally impressed can best be assured by putting a solid evaluation and research oriented data base within the program's implementation plans.

APPENDICES

Appendix A

Site Visitation Schedules

BOARD OF EDUCATION OF GARRETT COUNTY
40 South Fourth Street
P. O. Box 313
Oakland, Maryland 21550

Office of the Superintendent

(Area Code 301)
Telephone: 334-8121

March 25, 1983

Dr. Jim Dudley
University of Maryland
Center for Educational Research and Development
Division of Human and Community Resources
College of Education
College Park, MD 20742

Dear Dr. Dudley:

I am submitting the following revised schedule to you for the RESA/University of Maryland Evaluation of the Berkeley/Primary Grades Health Curriculum in Garrett County on Thursday, March 31, 1983.

8:30 a.m. - 9:00 a.m. - Meet with: Dr. Jerome J. Ryscavage, Superintendent of Schools
Mr. Albert R. Ringer, Assistant Superintendent of Curriculum and Instruction
Mrs. Charleen Evans-Thomas, Director of Elementary Education and
Ms. Dorothy H. Nice, Secretary to Directors

Place: Garrett County Board of Education Office

Purpose: County overview of the two health projects, K-8

9:00 a.m. - 9:15 a.m. - Travel to Broad Ford Elementary School.

9:15 a.m. - 9:30 a.m. - Coffee with Mr. Wayne Johnson, Broad Ford School.

9:30 a.m. - 10:45 a.m. - Visit at school. Interview staff K-3. Observe classes K-3 teaching health, if possible.

10:45 a.m. - 11:30 a.m. - Travel to Friendsville Elementary School.

11:30 a.m. - 12:00 noon - Lunch at Friendsville Elementary School with principal.

12:00 noon - 1:15 p.m. - Interview staff K-3. Observe classes K-3 teaching health, if possible.

1:20 p.m. - 1:45 p.m. - Travel to Grantsville Elementary School.

1:45 p.m. - 3:00 p.m. - Visit at school. Interview staff 4-5 (Berkeley Health).

Principals of these schools are:

Mr. Wayne Johnson, Broad Ford Elementary, K-5
Mrs. Jane Fox, Friendsville Elementary, PK-5
Mr. Matthew Stieringer, Grantsville Elementary, K-5

If you have any questions or concerns, please contact me.

Sincerely,

Charleen Evans-Thomas

Mrs. Charleen Evans-Thomas
Director of Elementary Education

CET:dhn

cc: Dr. Jerome J. Ryscavage, Superintendent of Schools
Mr. Albert R. Ringer, Assistant Superintendent of Curriculum and Instruction
Mr. Wayne Johnson, Principal, Broad Ford Elementary
Mrs. Jane Fox, Principal, Friendsville Elementary School
Mr. Matthew Stieringer, Principal, Grantsville Elementary School

BOARD OF EDUCATION OF WASHINGTON COUNTY
P.O. BOX 730, COMMONWEALTH AVENUE, HAGERSTOWN, MARYLAND 21740 • PHONE: 791-4000

CLAUD E. KITCHENS
Superintendent

March 17, 1983

Dr. James Dudley
University of Maryland
Center for Education Research
and Development
Division of Human and Community Resources
College of Education
College Park, MD 20742

Dear Dr. Dudley:

Below is the schedule that I have devised for the Health Curriculum Review Committee's visit to Washington County on Tuesday, April 19, 1983.

8:30 a.m.- 9:10 a.m.	-	Meet with Mr. Ford, Central Office Board Room - Orientation
9:10 a.m.- 9:15 a.m.	-	Travel to Bester Elementary School
9:15 a.m.- 9:30 a.m.	-	Coffee and Danish with Mr. Don Kendall, Principal - Bester Elementary
9:30 a.m.-10:45 a.m.	-	Visit Classrooms and Interview Staff
10:45 a.m.-11:15 a.m.	-	Travel to Old Forge Elementary School
11:15 a.m.-12:00 p.m.	-	Lunch with Miss Nancy Martin, Principal - Old Forge Elementary
12:00 p.m.- 1:45 p.m.	-	Visit Classrooms and Interview Staff
1:45 p.m.- 2:15 p.m.	-	Travel to Board of Education
2:15 p.m.- 3:00 p.m.	-	Meet in Board Room with Central Office Staff: Mr. Thomas Downs, Director of Curriculum Mr. James Haught, Science Supervisor Mr. William Ford, Elementary Supervisor Others in Possible Attendance: Dr. Claud Kitchens, Superintendent Mr. Richard Whisner, Deputy Superintendent Mrs. Ann Frushour, Elementary Supervisor Mr. William Wright, Elementary Supervisor
3:00 p.m.-		Follow-up Session

Please contact me if you have any suggestions or concerns.

Sincerely,

Bill Ford

William G. Ford
Elementary Supervisor

WGF:hlw

cc: Dr. Claud E. Kitchens
Mr. Richard Whisner
Mr. Thomas Downs
Mr. James Haught
Mrs. Ann Frushour
Mr. William Wright
Mr. Donald Kendall
Miss Nancy Martin
Mr. George Allen

Welcome RESA
Visitation Schedule
April 19, 1983
Bester Elementary School

Agenda:

9:15 - 9:35 - Get acquainted and refreshments, in Faculty Lounge

Team I - 3 Visitors with Mr. Ford

9:40 - 10:00 - Kindergarten - Ms. Siuta, Room #K-B
Phase #4, Happiness Is A Healthy Me Always
Objectives: 1) Students prepare and serve a tasty and nutritious snack.
2) Students will identify food and food groups.

10:05 - 10:30 - Second Grades - Ms. Gonder, Mr. Gross, Rooms 5,7
Phase #3, Parts of the Ear - Gonder
The Workings of the Eye - "Gross"
Objectives: 1) To introduce the ear and parts of the ear.
2) Name eleven parts of the eye.
3) Describe briefly, function of each part.

10:30 - 10:45 - Meet and confer with Ms. Siuta, Mrs. Gonder, Mr. Gross and Team I Visitors - Faculty Lounge.

Team II - 2 Visitors with Ms. Thomas

9:40 - 10:20 - Third Grade - Ms. Pallas, Room #110
Phase #2, Appreciation of Muscles, Bones and Body Movement
Objectives: 1) To identify unsafe practices depicted on selected transparencies.
2) To state three water safety rules.
3) To make posters related to an activity or environment of their own choosing.
4) To state at least five rules for safety. at school and/or during leisure activities.
5) To state safety rules on:

a) preventing burns; b) preventing electric shock; 3) using medicines; d) responding to red danger signals.

Activities: Station oriented with Teacher/Aide assistance.

10:30 - 10:45 - Meet and confer with Ms. Pallas and Team II Visitors, Faculty Lounge.

Health Project Evaluation
April 20, 1983
Allegany County, Maryland

Agenda

8:30 A.M. - 8:45 A.M.	Convene at Office of Board of Education Allegany County, 108 Washington Street, Cumberland, Maryland
8:45 A.M. - 9:00 A.M.	Overview of Primary Grades and Berkeley Health Education Projects - Mary Malamphy
9:00 A.M. - 9:15 A.M.	Travel to Parkside Elementary School
9:15 A.M. - 9:30 A.M.	Meet with Mrs. Dorothy Dorn, Principal
9:30 A.M. - 11:30 A.M.	Observe projects, grades K - 4, and interview staff
11:30 A.M. - 12:30 P.M.	Eat lunch at Parkside
12:30 P.M. - 12:45 P.M.	Travel to West Side Elementary School
12:45 P.M. - 1:00 P.M.	Meet with Mr. John Festerman, Acting Principal
1:00 P.M. - 2:00 P.M.	Interview staff
2:00 P.M. - 3:00 P.M.	Observe Berkeley Project in grades 5 - 6

Appendix B

Evaluation Forms I and II

Health Curriculum Project

Evaluation Form I

_____ Project
(Complete Title)

Directions: This form is to be completed by the person(s) directly responsible for project implementation. The person(s) completing this form should be those most knowledgeable about the project's development, implementation, and adaptation since its inception. Since this task encompasses such a broad range of activities over an extended period of time, the person responsible for completing the form may need to seek advice and information from others in the district who are associated with the project.

A. Current status of the implementation of the project. (Check the appropriate response and complete the comment section as necessary.)

1. Project Status

_____ Fully in place throughout the system, all schools participating.
_____ Almost fully in place, with most (over 75%) schools participating.
_____ Partially in place with about half of the schools participating.
_____ Barely in place with only a few schools (25% or less) participating.
_____ Not in place at all.

Comments: _____

_____

_____

2. Has the Board of Education formally adopted this project?

	Yes	No
	___	___

Comments: _____

_____

3. If the project has not been fully implemented, what are the plans for further implementation?

_____

_____

_____

4. Quantitative Data: Program Size

Total Elem. Schools in System	Total Elem. Enrollment	No. of Schools in Project	Total Students in Project Schools
_____	_____	_____	_____

Comments: _____

_____

_____

B. Significant Implementation Steps and Procedures:

1. Management

a. Has project management and supervisory responsibility been clearly established?

_____ Yes _____ No (If no, indicate status) _____

_____

_____

b. Is the management/supervisory role a newly created position or was this responsibility attached to an existing role?

_____

_____

c. Briefly describe the position and the responsibilities of the person charged with this responsibility. _____

_____

_____

d. How would you describe the quality of project management?

_____ Well managed with only routine difficulties.

_____ Well managed but with some major difficulties that were completely resolved.

_____ Management was indefinite and not well defined at outset but improved as project developed so current status is solid.

_____ Other (please specify) _____

_____

Comments: _____

_____

_____

2. Materials utilization and control?

a. Have project materials proven to be satisfactory in most instances?

_____ Yes _____ No. If no, explain. _____

_____

_____

b. Has materials control (distribution and inventory) been a problem of significance?

_____ Yes _____ No. If yes, please explain. _____

_____

_____

c. Do material replacement costs pose a problem or question for the program's future?

_____ Yes _____ No. If yes, please explain. _____

_____

_____

d. Who is responsible for materials control?

At the system level _____

At the school level _____

At the classroom level _____

e. Have any procedures been established for materials control beyond those normally functioning in the system?

_____ Yes _____ No. If yes, please describe. _____

_____

_____

_____

3. Personnel Development

a. Were all participating principals and teachers provided orientation and training for the project prior to implementation?
Principals _____ Yes _____ No Classroom teachers _____ Yes _____ N

If no, please describe any variance.

_____

_____

_____

b. How would you describe the quality and thoroughness of the training provided to teachers?

_____ Excellent in every respect.

_____ Good, but could have been improved upon.

_____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

_____

_____

_____

c. How would you describe the quality and thoroughness of the training provided to principals?

_____ Excellent in every respect.

_____ Good, but could have been improved upon.

_____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

_____

_____

_____

Comments: _____

_____

_____

4. Project leadership at the central office level. (Commitment and involvement of key personnel at all levels to project success.)

   a. How would you describe project leadership as defined above?

      _____ Excellent throughout the structure.

      _____ Good in most instances.

      _____ Fair but needed some additional motivation at critical levels.

      If you checked either of the last two responses, please explain need for improvement. _____

      _____

      _____

   b. Was project leadership a significant determinant of project success at the central office level?

      _____ Yes _____ No

      Comments: _____

      _____

      _____

   c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

      _____ Superintendent

      _____ Assistant Superintendent

      _____ Supervisor for Health Education

      _____ Other, please specify

5. Project leadership at school level. (Commitment and involvement of key personnel at all levels to project success.)

   a. How would you describe project leadership as defined above?

      _____ Excellent throughout the structure.

      _____ Good in most instances.

      _____ Fair but needed some additional motivation at critical levels.

If you checked either of the last two responses, please explain need for improvement. _____

_____

_____

b. Was project leadership a significant determinant of project success at the school level?

_____ Yes _____ No

Comments: _____

_____

_____

c. If yes for above question, who generally provided the needed leadership? (Cehck as many as apply.)

_____ Principal

_____ Classroom teachers

_____ Other (specify)

6. Availability of Community Resources.

a. Was the availability of community resources a factor in project success?

_____ Yes _____ No

Comments: _____

_____

b. Was any training or orientation provided community personnel who worked in the project? _____ Yes _____ No

Comments: _____

_____

_____

c. Name several community resources (human and material) which proved important to project implementation.

_____

_____

_____

_____

_____

_____

Comments: _____

_____

_____

C. Project Maintenance. (Activities seen as necessary to keeping the project on target once implemented.)

1. Has project maintenance placed an increased strain on system resources?

_____ Yes _____ No If yes, explain. _____

_____

_____

2. What, if anything, needs to be done to assure continued top management (Board and Superintendent) support for the project?

_____

_____

_____

_____

3. What is being done to assure continuing community involvement?

_____

_____

_____

4. What is being done to assure continued teacher interest and support? (Check those which apply.)

_____ Additional training and development.

_____ Opportunities to serve as resource people to other teachers in the system.

_____ Opportunities to serve as resource people to other systems.

_____ Other (Please specify). _____

_____

_____

6. Pupil Interest.

a. Has the maintenance of pupil interest and motivation become a concern since implementation?

_____ Yes. _____ No. If yes, please explain. _____

_____

_____

b. Are there any special efforts to maintain pupil interest? (Check any that apply.)

_____ Awards programs.

_____ Special progress reports to students and parents.

_____ Changes in program elements.

_____ Others (Please specify) _____

_____

_____

C. Have there been any noteworthy adaptations in the project to improve its quality and usefulness to your system? (Explain all that you check.)

_____ In areas of personnel development. _____

_____

_____

_____ In areas of management. _____

_____

_____

_____ In areas of materials development and revision. _____

_____

_____

_____In areas of leadership (as described above). _____

_____

_____

_____ In areas of community involvement. _____

_____

_____

_____ To cope with variances in population sparsity or density.

_____

_____

_____

_____ In area of parental inclusion and involvement. _____

_____

_____

D. What have been some of the most noteworthy achievements that have come about as a result of this curriculum improvement effort?

_____

_____

_____

_____

_____

_____

_____

_____

E. Future Plans (Changes or improvements anticipated over next 5 years.)

Please describe any plans or expectations that you and/or the system holds for program improvement and change over the next five years. If these changes involve the elimination or integration of the health curriculum with other curricula elements, please explain.

Health Curriculum Project

Evaluation Form II

_____

(Project Name)

Directions: This form is to be completed by a member of the visitation team. Entries are to be based on the responses of interviews and on the observation of the team member at the program site.

I. Interview Data

A. Descriptive data of person being interviewed.

1. Role of the person being interviewed. _____

2. Number of years associated with program. _____

3. Nature of previous participation if other than present role. _____

_____

B. Interviewee's Perception of Program

1. What orientation and development was provided you for your role?

_____

_____

_____

_____

2. What is your impression as to the quality of the materials, equipment and supplies available to implement the program?

_____

_____

_____

_____

3. Were these things available in sufficient quantities?

_____ Yes _____ No. Comment. _____

_____

_____

_____

_____

4. How would you describe the management of this program?

5. What was the extent and nature of community involvement?

6. What was the general availability of community resources?

7. What was the general quality level of the human resources which came from the community?

8. What can you tell us about the general level of parental acceptance?

9. Parental Involvement?

C. Interviewee's Concerns and Expectations for Program's Future.

1. What is your estimate of long term top management support for this program?

2. What needs to be done to bring about materials revision and improvement?

3. What can be done to assure strong community involvement?

4. What staff (teacher/principal) developments needs do you foresee for the immediate future?

5. Do you believe that the program as currently implemented will have a a favorable impact on the growth and development of pupil's enrolled in it?

6. Other concerns/comments.

D. Interviewee's Perception of Most Noteworthy Aspects of Program.

1. What impact has the program had on pupil development to date?

2. What has been the program's impact on other program areas (teaching models, material usage, etc.)?

3. What impact, if any, has the program had on the personal health habits of adults associated with it?

4. Other noteworthy happenings?

II. Observation Data. (Team member should use this section for recording personal observations of project activities, structures, and materials.)

A. Evidence of project management (Materials, space arrangements, adequacy of personnel, schedules, evaluation procedures, etc.)

B. Evidence of leadership. (Commitment, enthusiasium, program vitality, statements of support and respect, etc.)

C. Evidence of personnel preparation and competence (Knowledge of program, capacity to adapt to differing conditions, creativity in use of materials, space.).

D. Evidence of Pupil Response (Interest, motivation, attentiveness, statement of support, etc.).

E. Evidence of community involvement and support (presence or evidence of presence of community support.).

F. Other (Please specify)

G. Most noteworthy aspects of program based on interviewer's observations and assessments.

Appendix C

Completed Version of Evaluation Form I

Health Curriculum Project

Evaluation Form I

Primary Grades

Washington County Proje
(Complete Title)

Directions: This form is to be completed by the person(s) directly responsible for project implementation. The person(s) completing this form should be those most knowledgeable about the project's development, implementation, and adaptation since its inception. Since this task encompasses such a broad range of activities over an extended period of time, the person responsible for completing the form may need to seek advice and information from others in the district who are associated with the project.

A. Current status of the implementation of the project. (Check the appropriate response and complete the comment section as necessary.)

1. Project Status

_____ Fully in place throughout the system, all schools participating.

_____ Almost fully in place, with most (over 75%) schools participating.

_X_ Partially in place with about half of the schools participating.

_____ Barely in place with only a few schools (25% or less) participating.

_____ Not in place at all.

Comments: The Primary Health Curriculum is in 23 of our 27 elementary schools. Exactly half of our teachers trained.

2. Has the Board of Education formally adopted this project?

Yes	No
X	___

Comments: _____

3. If the project has not been fully implemented, what are the plans for further implementation?

We plan to have all of our teachers fully trained before the start of school in September, 1983.

4. Quantitative Data: Program Size

Total Elem. Schools in System	Total Elem. Enrollment	No. of Schools in Project	Total Students in Project Schools
27	4,783	24	2,330

Comments: _____

B. Significant Implementation Steps and Procedures:

1. Management

a. Has project management and supervisory responsibility been clearly established?

__X__ Yes _____ No (If no, indicate status) _____

b. Is the management/supervisory role a newly created position or was this responsibility attached to an existing role?

It was an existing role with a new supervisor taking responsibility for K-5 as of September, 1982.

c. Briefly describe the position and the responsibilities of the person charged with this responsibility. One elementary supervisor has the responsibility of the health curriculum, K-5. He is responsible for all workshops, training, and materials. He must also oversee the entire health curriculum.

d. How would you describe the quality of project management?

_____ Well managed with only routine difficulties.

_____ Well managed but with some major difficulties that were completely resolved.

_____ Management was indefinite and not well defined at outset but improved as project developed so current status is solid.

__X__ Other (please specify) Well managed but with some major difficulties that are yet to be resolved.

Comments: _____

2. Materials utilization and control?

a. Have project materials proven to be satisfactory in most instances?

__X__ Yes _____ No. If no, explain. _____

b. Has materials control (distribution and inventory) been a problem of significance?

__X__ Yes _____ No. If yes, please explain. Materials must be shared between schools. No two teachers maintain the material to the same degree.

c. Do material replacement costs pose a problem or question for the program's future?

__X__ Yes _____ No. If yes, please explain. We are approximately $100,000 away from an excellent implementation. We are maybe looking at five years.

d. Who is responsible for materials control?

At the system level Elementary Supervisor

At the school level Media Specialist - 1983-84

At the classroom level Classroom Teacher

a. Have any procedures been established for materials control beyond those normally functioning in the system?

____ Yes __X__ No. If yes, please describe. _____

3. Personnel Development

a. Were all participating principals and teachers provided orientation and training for the project prior to implementation?
Principals ____ Yes __X__ No Classroom teachers ____ Yes __X__

If no, please describe any variance.

Only two principals are trained. All will be trained this summer.
Thus for there has only been enough funds to train half of our teachers.

b. How would you describe the quality and thoroughness of the training provided to teachers?

__X__ Excellent in every respect.

____ Good, but could have been improved upon.

____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

c. How would you describe the quality and thoroughness of the training provided to principals?

____ Excellent in every respect.

____ Good, but could have been improved upon.

__X__ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Principals not trained

Comments: _____

_____

_____

4. Project leadership at the central office level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

__X__ Excellent throughout the structure.

_____ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

If you checked either of the last two responses, please explain need for improvement. Leadership role is well defined now. We know who has what responsibilities and where we are headed.

_____

b. Was project leadership a significant determinant of project success at the central office level?

__X__ Yes _____ No

Comments: There were too many responsibilities for one person prior to this school year.

_____

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Superintendent

_____ Assistant Superintendent

__X__ Supervisor for Health Education

_____ Other, please specify

5. Project leadership at school level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

_____ Good in most instances.

__X__ Fair but needed some additional motivation at critical levels.

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If you checked either of the last two responses, please explain need for improvement. Principals were not required to be trained; thus, it is very difficult for them to show leadership in the health curriculum.

b. Was project leadership a significant determinant of project success at the school level?

X Yes ____ No

Comments:

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

____ Principal

X Classroom teachers - Teachers asking Principals for advice

X Other (specify) - Principals then having to call their supervisor for an answer.

6. Availability of Community Resources.

a. Was the availability of community resources a factor in project success?

____ Yes X No

Comments: In most cases, help has been readily available.

b. Was any training or orientation provided community personnel who worked in the project? ____ Yes X No

Comments:

c. Name several community resources (human and material) which proved important to project implementation.

American Cancer Society

American Lung Association

National Dairy Council

Community Rescue Agencies

Washington County Health Department

Local physicians and dentists

Comments: _____

C. Project Maintenance. (Activities seen as necessary to keeping the project on target once implemented.)

1. Has project maintenance placed an increased strain on system resources?

____ Yes X No If yes, explain. Not at this time. However, we are still aiming for full implementation.

2. What, if anything, needs to be done to assure continued top management (Board and Superintendent) support for the project?

We have all the staff support that we could ask for. We will need constant financial and verbal support from our elected board members.

3. What is being done to assure continuing community involvement?

Not over use of the same people. Reminder to teachers from principals and supervisors to use outside sources.

4. What is being done to assure continued teacher interest and support? (Check those which apply.)

X Additional training and development.

____ Opportunities to serve as resource people to other teachers in the system.

____ Opportunities to serve as resource people to other systems.

X Other (Please specify). Science Fairs, PTA and other such meetings being utilized to demonstrate our health curriculum.

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6. Pupil Interest.

a. Has the maintenance of pupil interest and motivation become a concern since implementation?

____ Yes. _X_ No. If yes, please explain. _____

b. Are there any special efforts to maintain pupil interest? (Check any that apply.)

_X_ Awards programs.

_X_ Special progress reports to students and parents.

____ Changes in program elements.

____ Others (Please specify) In some schools, both students and volunteers have received awards.

C. Have there been any noteworthy adaptations in the project to improve its quality and usefulness to your system? (Explain all that you check.)

_X_ In areas of personnel development. We have developed outstanding trainers.

_X_ In areas of management. Routing schedules, inventories materials control at school level

____ In areas of materials development and revision. _____

_X_ In areas of leadership (as described above). Principals will be trained. Board level responsibilities are now defined.

____ In areas of community involvement. _____

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____ To cope with variances in population sparsity or density.

X In area of parental inclusion and involvement. Many schools are beginning to involve more parent volunteers.

D. What have been some of the most noteworthy achievements that have come about as a result of this curriculum improvement effort?

Outstanding training has promoted high interest among teachers now involved with the curriculum.

Parents have high praise for the program.

Students enjoy "doing" health

E. Future Plans (Changes or improvements anticipated over next 5 years.)

Please describe any plans or expectations that you and/or the system holds for program improvement and change over the next five years. If these changes involve the elimination or integration of the health curriculum with other curricula elements, please explain.

By 1988 we hope to have full implementation of the primary health curriculum. We hope to have kits in all schools; thus, eliminating any sharing between two or more schools.

Every four or five years we plan to have training workshops for teachers new to our system or teachers that have moved on to another grade level.

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Health Curriculum Project

Evaluation Form I

Berkeley Project
Washington County Proje:
(Complete Title)

Directions: This form is to be completed by the person(s) directly responsible for project implementation. The person(s) completing this form should be those most knowledgeable about the project's development, implementation, and adaptation since its inception. Since this task encompasses such a broad range of activities over an extended period of time, the person responsible for completing the form may need to seek advice and information from others in the district who are associated with the project.

A. Current status of the implementation of the project. (Check the appropriate response and complete the comment section as necessary.)

1. Project Status

____ Fully in place throughout the system, all schools participating.
____ Almost fully in place, with most (over 75%) schools participating.
____ Partially in place with about half of the schools participating.
_X_ Barely in place with only a few schools (25% or less) participating.
____ Not in place at all.

Comments: Only four schools are presently involved in Berkeley. However, their programs are limited to the few basic materials that they have available in their schools.

2. Has the Board of Education formally adopted this project?

Yes	No
X	___

Comments: _____

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3. If the project has not been fully implemented, what are the plans for further implementation?

We plan to develop a unit - Best of Berkeley - this summer and train all grade four and five teachers.

4. Quantitative Data: Program Size

Total Elem. Schools in System	Total Elem. Enrollment	No. of Schools in Project	Total Students in Project Schools
29	2,632 (Gr. 4-5)	4	250

Comments:

B. Significant Implementation Steps and Procedures:

1. Management

a. Has project management and supervisory responsibility been clearly established?

X Yes ____ No (If no, indicate status) ____

b. Is the management/supervisory role a newly created position or was this responsibility attached to an existing role?

It was an existing role with a new supervisor taking responsibility for K-5 as of September, 1982.

c. Briefly describe the position and the responsibilities of the person charged with this responsibility. One elementary supervisor has the responsibility of the health curriculum, K-5. He is responsible for all workshops, training and materials. He must also oversee the entire health curriculum.

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d. How would you describe the quality of project management?

_____ Well managed with only routine difficulties.

_____ Well managed but with some major difficulties that were completely resolved.

_____ Management was indefinite and not well defined at outset but improved as project developed so current status is solid.

__X__ Other (please specify) Well managed but with some major difficulties that are yet to be resolved.

Comments: _____

2. Materials utilization and control?

a. Have project materials proven to be satisfactory in most instances?

__X__ Yes _____ No. If no, explain. _____

b. Has materials control (distribution and inventory) been a problem of significance?

__X__ Yes _____ No. If yes, please explain. With the loss of a coordinator, control was lost. Presently, there is very little material to be found in the county.

c. Do material replacement costs pose a problem or question for the program's future?

__X__ Yes _____ No. If yes, please explain. Limited funds will determine our program.

d. Who is responsible for materials control?

At the system level Elementary Supervisor

At the school level NA

At the classroom level NA

e. Have any procedures been established for materials control beyond those normally functioning in the system?

____ Yes __X__ No. If yes, please describe. _____

3. Personnel Development

a. Were all participating principals and teachers provided orientation and training for the project prior to implementation?
Principals ____ Yes __X__ No Classroom teachers ____ Yes __X__

If no, please describe any variance.

Very limited training in all areas.

b. How would you describe the quality and thoroughness of the training provided to teachers?

__X__ Excellent in every respect.

____ Good, but could have been improved upon.

____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

c. How would you describe the quality and thoroughness of the training provided to principals?

____ Excellent in every respect.

____ Good, but could have been improved upon.

__X__ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Principals not trained.

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Comments: _____

_____

_____

4. Project leadership at the central office level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

__X__ Excellent throughout the structure.

_____ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

If you checked either of the last two responses, please explain need for improvement. Leadership role is well defined. We now know who has what responsibilities and where we are headed.

_____

b. Was project leadership a significant determinant of project success at the central office level?

__X__ Yes _____ No

Comments: There were too many responsibilities for one person prior to this year.

_____

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Superintendent

_____ Assistant Superintendent

__X__ Supervisor for Health Education

_____ Other, please specify

5. Project leadership at school level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

_____ Good in most instances.

__X__ Fair but needed some additional motivation at critical levels.

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If you checked either of the last two responses, please explain need for improvement. Many principals were not trained; thus, it is very difficult for them to show leadership in the health curriculum.

b. Was project leadership a significant determinant of project success at the school level?

__X__ Yes _____ No

Comments: _____

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Principal

__X__ Classroom teachers

_____ Other (specify)

6. Availability of Community Resources.

a. Was the availability of community resources a factor in project success?

_____ Yes __X__ No

Comments: _____

b. Was any training or orientation provided community personnel who worked in the project? _____ Yes __X__ No

Comments: _____

c. Name several community resources (human and material) which proved important to project implementation.

American Cancer Society

American Lung Association

National Dairy Council

Community Rescue Agencies

Washington County Health Department

Local Physicians

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Comments: _____

_____

_____

C. Project Maintenance. (Activities seen as necessary to keeping the project on target once implemented.)

1. Has project maintenance placed an increased strain on system resources?

_____ Yes __X__ No If yes, explain. As material was lost or destroyed, there were no funds available to replace them. No funds to train more teachers.

2. What, if anything, needs to be done to assure continued top management (Board and Superintendent) support for the project?

Financial support from our elected board of education.

_____

_____

_____

3. What is being done to assure continuing community involvement?

NA at this time.

_____

_____

4. What is being done to assure continued teacher interest and support? (Check those which apply.)

__X__ Additional training and development.

_____ Opportunities to serve as resource people to other teachers in the system.

_____ Opportunities to serve as resource people to other systems.

_____ Other (Please specify). _____

_____

_____

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6. Pupil Interest.

a. Has the maintenance of pupil interest and motivation become a concern since implementation?

_____ Yes. __X__ No. If yes, please explain. _____

b. Are there any special efforts to maintain pupil interest? (Check any that apply.)

__X__ Awards programs.

__X__ Special progress reports to students and parents.

_____ Changes in program elements.

_____ Others (Please specify) Awards have been given to students and volunteers.

C. Have there been any noteworthy adaptations in the project to improve its quality and usefulness to your system? (Explain all that you check.)

_____ In areas of personnel development. _____

_____ In areas of management. _____

__X__ In areas of materials development and revision. See E

__x__ In areas of leadership (as described above). Principals will be trained. Board level responsibilities are now defined.

_____ In areas of community involvement. _____

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_____ To cope with variances in population sparsity or density.

_____

_____

_____

_____ In area of parental inclusion and involvement. _____

_____

_____

D. What have been some of the most noteworthy achievements that have come about as a result of this curriculum improvement effort?

_____

_____

_____

_____

_____

_____

_____

_____

E. Future Plans (Changes or improvements anticipated over next 5 years.)

Please describe any plans or expectations that you and/or the system holds for program improvement and change over the next five years. If these changes involve the elimination or integration of the health curriculum with other curricula elements, please explain.

We have two county developed "hands-on" science units in grades four and five. This summer we plan to develop another science unit and a health unit for grades four and five.

The health unit will be based on the "Best of Berkeley." It will be a "hands-on unit" that will not require sharing of materials between schools.

We hope to have both the science and health implemented into our curriculum for the 1983-84 school year.

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Health Curriculum Project

Evaluation Form I

Allegany County
Berkeley Project Proje
(Complete Title)

Directions: This form is to be completed by the person(s) directly responsible for project implementation. The person(s) completing this form should be those most knowledgeable about the project's development, implementation, and adaptation since its inception. Since this task encompasses such a broad range of activities over an extended period of time, the person responsible for completing the form may need to seek advice and information from others in the district who are associated with the project.

A. Current status of the implementation of the project. (Check the appropriate response and complete the comment section as necessary.)

1. Project Status

X Fully in place throughout the system, all schools participating.

____ Almost fully in place, with most (over 75%) schools participating.

____ Partially in place with about half of the schools participating.

____ Barely in place with only a few schools (25% or less) participating.

____ Not in place at all.

Comments: _____

2. Has the Board of Education formally adopted this project?

Yes	No
X	___

Comments: Satisfies the State mandate for a health education program.

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3. If the project has not been fully implemented, what are the plans for further implementation?

4. Quantitative Data: Program Size

Total Elem. Schools in System	Total Elem. Enrollment	No. of Schools in Project	Total Students in Project Schools
22	3,747	27 (some middle)	3,747

Comments: Program implemented grades 4 - 7

5. Significant Implementation Steps and Procedures:

1. Management

a. Has project management and supervisory responsibility been clearly established?

X Yes ____ No (If no, indicate status) ____

b. Is the management/supervisory role a newly created position or was this responsibility attached to an existing role?

Attached to existing roles

c. Briefly describe the position and the responsibilities of the person charged with this responsibility. Serve as supervisor of elementary schools responsible for supervision of all areas of the curriculum and teachers in eight schools.

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d. How would you describe the quality of project management?

__X__ Well managed with only routine difficulties.

_____ Well managed but with some major difficulties that were completely resolved.

_____ Management was indefinite and not well defined at outset but improved as project developed so current status is solid.

_____ Other (please specify) _____

Comments: _____

2. Materials utilization and control?

a. Have project materials proven to be satisfactory in most instances?

__X__ Yes _____ No. If no, explain. Materials for replacement become a concern because they are no longer available from publishers or a.v. jobbers.

b. Has materials control (distribution and inventory) been a problem of significance?

_____ Yes __X__ No. If yes, please explain. Could become one as school system budget decreases occur.

c. Do material replacement costs pose a problem or question for the program's future?

_____ Yes __X__ No. If yes, please explain. We are addressing this problem at the present time.

d. Who is responsible for materials control?

At the system level Supervisor of Elementary Education - Mary Malamphy

At the school level Principal

At the classroom level Teacher

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e. Have any procedures been established for materials control beyond those normally functioning in the system?

__X__ Yes _____ No. If yes, please describe. An aide contributing 30% of his/her time has been available at the county housing site to inventory materials, to prepare kits for distribution, and to provide on-going servicing as needed during the school year.

3. Personnel Development

a. Were all participating principals and teachers provided orientation and training for the project prior to implementation?
Principals __X__ Yes _____ No Classroom teachers __X__ Yes ___

If no, please describe any variance.

Some training has been on the job with lead teachers providing assistance where teaching assignments have been changed due to reduced staffing.

b. How would you describe the quality and thoroughness of the training provided to teachers?

_____ Excellent in every respect.

__X__ Good, but could have been improved upon.

_____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Subsequent training after implementation would be beneficial for all personnel involved. New health knowledge and introduction of revised guides would be better handled during sessions.

c. How would you describe the quality and thoroughness of the training provided to principals?

_____ Excellent in every respect.

__X__ Good, but could have been improved upon.

_____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Same as above.

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Comments: _____

_____

_____

4. Project leadership at the central office level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

__X__ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

If you checked either of the last two responses, please explain need for improvement. A supervisor who could allocate at least 40% of his/her time to health program supervision and maintenance would enhance the quality of the program.

b. Was project leadership a significant determinant of project success at the central office level?

__X__ Yes _____ No

Comments: Responsibility of same person since 1972.

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Superintendent

__X__ Assistant Superintendent Delegated responsibility for implementation to person listed below.

_____ Supervisor for Health Education

__X__ Other, please specify Supervisor of Elementary Education, Family Life Coordinator and Supervisor of Science (7 - 12)

5. Project leadership at school level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

__X__ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

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If you checked either of the last two responses, please explain need for improvement. Health program responsibility just one of many required of project coordinator

b. Was project leadership a significant determinant of project success at the school level?

X Yes ____ No

Comments: Principal involvement in team training resulted in personal commitment for optimal program implementation at school level.

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

X Principal

X Classroom teachers

____ Other (specify)

6. Availability of Community Resources.

a. Was the availability of community resources a factor in project success?

X Yes ____ No

Comments: ____

b. Was any training or orientation provided community personnel who worked in the project? X Yes ____ No

Comments: Originally county health nurses were involved in training sessions. Community agency personnel often participated during teacher training sessions.

c. Name several community resources (human and material) which proved important to project implementation.

Lung Association Cancer Society

Red Cross

Heart Association

Health Department Personnel, Dental Hygienists

Rescue Squads and Fire Departments

Frostburg State College, Allegany Community College

Dental Society

Sacred Heart and Memorial Hospitals

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Comments: _____

C. Project Maintenance. (Activities seen as necessary to keeping the project on target once implemented.)

1. Has project maintenance placed an increased strain on system resources?

X Yes ____ No If yes, explain. Since the health program has been a priority, funding each fiscal year has been available for program maintenance.

2. What, if anything, needs to be done to assure continued top management (Board and Superintendent) support for the project?

3. What is being done to assure continuing community involvement?

Continuing contact with community agencies from central office project leader

4. What is being done to assure continued teacher interest and support? (Check those which apply.)

____ Additional training and development.

X Opportunities to serve as resource people to other teachers in the system.

____ Opportunities to serve as resource people to other systems.

X Other (Please specify). Each teacher is aware that the health program continues to be a vital part of the elementary program. Many Project Basic competencies are an integral part of the health curriculum. No additional survival skill activities need to be included in other curriculum areas to assure Project Basic compliance. All teachers are required to teach Project Basic.

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6. Pupil Interest.

a. Has the maintenance of pupil interest and motivation become a concern since implementation?

_____ Yes. __X__ No. If yes, please explain. _____

b. Are there any special efforts to maintain pupil interest? (Check any that apply.)

_____ Awards programs.

_____ Special progress reports to students and parents.

__X__ Changes in program elements.

_____ Others (Please specify) Duplication of experiences eliminated at subsequent grade levels 4 - 7 as program was implemented.

C. Have there been any noteworthy adaptations in the project to improve its quality and usefulness to your system? (Explain all that you check.)

_____ In areas of personnel development. _____

_____ In areas of management. _____

_____ In areas of materials development and revision. There will be a workshop conducted in May, 1983 to update, revise and purchase new materials to replace those no longer available.

_____ In areas of leadership (as described above). _____

_____ In areas of community involvement. _____

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_____ To cope with variances in population sparsity or density.

_____ In area of parental inclusion and involvement. _____

D. What have been some of the most noteworthy achievements that have come about as a result of this curriculum improvement effort?

E. Future Plans (Changes or improvements anticipated over next 5 years.)

Please describe any plans or expectations that you and/or the system holds for program improvement and change over the next five years. If these changes involve the elimination or integration of the health curriculum with other curricula elements, please explain.

Program update and material replacement will occur and contribute to program maintenance during the next five years. Periodic review and imput from administrative and instructional personnel will ensure that current level of commitment and program implementation is maintained.

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Health Curriculum Project

Evaluation Form I

Primary Grades

Washington County Proje
(Complete Title)

Directions: This form is to be completed by the person(s) directly responsible for project implementation. The person(s) completing this form should be those most knowledgeable about the project's development, implementation, and adaptation since its inception. Since this task encompasses such a broad range of activities over an extended period of time, the person responsible for completing the form may need to seek advice and information from others in the district who are associated with the project.

A. Current status of the implementation of the project. (Check the appropriate response and complete the comment section as necessary.)

1. Project Status

_____ Fully in place throughout the system, all schools participating.

_____ Almost fully in place, with most (over 75%) schools participating.

_X_ Partially in place with about half of the schools participating.

_____ Barely in place with only a few schools (25% or less) participating.

_____ Not in place at all.

Comments: The Primary Health Curriculum is in 23 of our 27 elementary schools. Exactly half of our teachers trained.

2. Has the Board of Education formally adopted this project?

Yes	No
X	___

Comments: _____

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3. If the project has not been fully implemented, what are the plans for further implementation?

We plan to have all of our teachers fully trained before the start of school in September, 1983.

4. Quantitative Data: Program Size

Total Elem. Schools in System	Total Elem. Enrollment	No. of Schools in Project	Total Students in Project Schools
27	4,783	24	2,330

Comments: _____

B. Significant Implementation Steps and Procedures:

1. Management

a. Has project management and supervisory responsibility been clearly established?

__X__ Yes _____ No (If no, indicate status) _____

b. Is the management/supervisory role a newly created position or was this responsibility attached to an existing role?

It was an existing role with a new supervisor taking responsibility for K-5 as of September, 1982.

c. Briefly describe the position and the responsibilities of the person charged with this responsibility. One elementary supervisor has the responsibility of the health curriculum, K-5. He is responsible for all workshops, training, and materials. He must also oversee the entire health curriculum.

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d. How would you describe the quality of project management?

_____ Well managed with only routine difficulties.

_____ Well managed but with some major difficulties that were completely resolved.

_____ Management was indefinite and not well defined at outset but improved as project developed so current status is solid.

__X__ Other (please specify) Well managed but with some major difficulties that are yet to be resolved.

Comments: _____

2. Materials utilization and control?

a. Have project materials proven to be satisfactory in most instances?

__X__ Yes _____ No. If no, explain. _____

b. Has materials control (distribution and inventory) been a problem of significance?

__X__ Yes _____ No. If yes, please explain. Materials must be shared between schools. No two teachers maintain the material to the same degree.

c. Do material replacement costs pose a problem or question for the program's future?

__X__ Yes _____ No. If yes, please explain. We are approximately $100,000 away from an excellent implementation. We are maybe looking at five years.

d. Who is responsible for materials control?

At the system level Elementary Supervisor

At the school level Media Specialist - 1983-84

At the classroom level Classroom Teacher

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e. Have any procedures been established for materials control beyond those normally functioning in the system?

____ Yes _X_ No. If yes, please describe. _____

3. Personnel Development

a. Were all participating principals and teachers provided orientation and training for the project prior to implementation?
Principals ____ Yes _X_ No Classroom teachers ____ Yes _X_

If no, please describe any variance.

Only two principals are trained. All will be trained this summer.
Thus for there has only been enough funds to train half of our teachers.

b. How would you describe the quality and thoroughness of the training provided to teachers?

_X_ Excellent in every respect.

____ Good, but could have been improved upon.

____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

c. How would you describe the quality and thoroughness of the training provided to principals?

____ Excellent in every respect.

____ Good, but could have been improved upon.

_X_ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Principals not trained

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Comments: _____

_____

_____

4. Project leadership at the central office level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

__X__ Excellent throughout the structure.

_____ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

If you checked either of the last two responses, please explain need for improvement. Leadership role is well defined now. We know who has what responsibilities and where we are headed.

_____

b. Was project leadership a significant determinant of project success at the central office level?

__X__ Yes _____ No

Comments: There were too many responsibilities for one person prior to this school year.

_____

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Superintendent

_____ Assistant Superintendent

__X__ Supervisor for Health Education

_____ Other, please specify

5. Project leadership at school level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

_____ Good in most instances.

__X__ Fair but needed some additional motivation at critical levels.

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If you checked either of the last two responses, please explain need for improvement. Principals were not required to be trained; thus, it is very difficult for them to show leadership in the health curriculum.

b. Was project leadership a significant determinant of project success at the school level?

__X__ Yes _____ No

Comments: _____

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Principal

__X__ Classroom teachers - Teachers asking Principals for advice

__X__ Other (specify) - Principals then having to call their supervisor for an answer.

6. Availability of Community Resources.

a. Was the availability of community resources a factor in project success?

_____ Yes __X__ No

Comments: In most cases, help has been readily available.

b. Was any training or orientation provided community personnel who worked in the project? _____ Yes __X__ No

Comments: _____

c. Name several community resources (human and material) which proved important to project implementation.

American Cancer Society

American Lung Association

National Dairy Council

Community Rescue Agencies

Washington County Health Department

Local physicians and dentists

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Comments: _____

C. Project Maintenance. (Activities seen as necessary to keeping the project on target once implemented.)

1. Has project maintenance placed an increased strain on system resources?

____ Yes ___X___ No If yes, explain. Not at this time. However, we are still aiming for full implementation.

2. What, if anything, needs to be done to assure continued top management (Board and Superintendent) support for the project?

We have all the staff support that we could ask for. We will need constant financial and verbal support from our elected board members.

3. What is being done to assure continuing community involvement?

Not over use of the same people. Reminder to teachers from principals and supervisors to use outside sources.

4. What is being done to assure continued teacher interest and support? (Check those which apply.)

___X___ Additional training and development.

____ Opportunities to serve as resource people to other teachers in the system.

____ Opportunities to serve as resource people to other systems.

___X___ Other (Please specify). Science Fairs, PTA and other such meetings being utilized to demonstrate our health curriculum.

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6. Pupil Interest.

a. Has the maintenance of pupil interest and motivation become a concern since implementation?

_____ Yes. __X__ No. If yes, please explain. _____

b. Are there any special efforts to maintain pupil interest? (Check any that apply.)

__X__ Awards programs.

__X__ Special progress reports to students and parents.

_____ Changes in program elements.

_____ Others (Please specify) In some schools, both students and volunteers have received awards.

C. Have there been any noteworthy adaptations in the project to improve its quality and usefulness to your system? (Explain all that you check.)

__X__ In areas of personnel development. We have developed outstanding trainers.

__X__ In areas of management. Routing schedules, inventories materials control at school level

_____ In areas of materials development and revision.

__X__ In areas of leadership (as described above). Principals will be trained. Board level responsibilities are now defined.

_____ In areas of community involvement.

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____ To cope with variances in population sparsity or density.

X In area of parental inclusion and involvement. Many schools are beginning to involve more parent volunteers.

D. What have been some of the most noteworthy achievements that have come about as a result of this curriculum improvement effort?

Outstanding training has promoted high interest among teachers now involved with the curriculum.

Parents have high praise for the program.

Students enjoy "doing" health

E. Future Plans (Changes or improvements anticipated over next 5 years.)

Please describe any plans or expectations that you and/or the system holds for program improvement and change over the next five years. If these changes involve the elimination or integration of the health curriculum with other curricula elements, please explain.

By 1988 we hope to have full implementation of the primary health curriculum. We hope to have kits in all schools; thus, eliminating any sharing between two or more schools.

Every four or five years we plan to have training workshops for teachers new to our system or teachers that have moved on to another grade level.

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Health Curriculum Project

Evaluation Form I

Berkeley Project
Washington County Proje
(Complete Title)

Directions: This form is to be completed by the person(s) directly responsible for project implementation. The person(s) completing this form should be those most knowledgeable about the project's development, implementation, and adaptation since its inception. Since this task encompasses such a broad range of activities over an extended period of time, the person responsible for completing the form may need to seek advice and information from others in the district who are associated with the project.

A. Current status of the implementation of the project. (Check the appropriate response and complete the comment section as necessary.)

1. Project Status

_____ Fully in place throughout the system, all schools participating.
_____ Almost fully in place, with most (over 75%) schools participating.
_____ Partially in place with about half of the schools participating.
__X__ Barely in place with only a few schools (25% or less) participating.
_____ Not in place at all.

Comments: Only four schools are presently involved in Berkeley. However, their programs are limited to the few basic materials that they have available in their schools.

2. Has the Board of Education formally adopted this project?

Yes	No
X	___

Comments: _____

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3. If the project has not been fully implemented, what are the plans for further implementation?

We plan to develop a unit - Best of Berkeley - this summer and train all grade four and five teachers.

4. Quantitative Data: Program Size

Total Elem. Schools in System	Total Elem. Enrollment	No. of Schools in Project	Total Students in Project School
29	2,632 (Gr. 4-5)	4	250

Comments:

B. Significant Implementation Steps and Procedures:

1. Management

a. Has project management and supervisory responsibility been clearly established?

X Yes ____ No (If no, indicate status) ____

b. Is the management/supervisory role a newly created position or was this responsibility attached to an existing role?

It was an existing role with a new supervisor taking responsibility for K-5 as of September, 1982.

c. Briefly describe the position and the responsibilities of the person charged with this responsibility. One elementary supervisor has the responsibility of the health curriculum, K-5. He is responsible for all workshops, training and materials. He must also oversee the entire health curriculum.

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d. How would you describe the quality of project management?

_____ Well managed with only routine difficulties.

_____ Well managed but with some major difficulties that were completely resolved.

_____ Management was indefinite and not well defined at outset but improved as project developed so current status is solid.

__X__ Other (please specify) Well managed but with some major difficulties that are yet to be resolved.

Comments: _____

2. Materials utilization and control?

a. Have project materials proven to be satisfactory in most instances?

__X__ Yes _____ No. If no, explain. _____

b. Has materials control (distribution and inventory) been a problem of significance?

__X__ Yes _____ No. If yes, please explain. With the loss of a coordinator, control was lost. Presently, there is very little material to be found in the county.

c. Do material replacement costs pose a problem or question for the program's future?

__X__ Yes _____ No. If yes, please explain. Limited funds will determine our program.

d. Who is responsible for materials control?

At the system level Elementary Supervisor

At the school level NA

At the classroom level NA

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e. Have any procedures been established for materials control beyond those normally functioning in the system?

____ Yes __X__ No. If yes, please describe. _____

3. Personnel Development

a. Were all participating principals and teachers provided orientation and training for the project prior to implementation?
Principals ____ Yes __X__ No Classroom teachers ____ Yes __X__

If no, please describe any variance.

Very limited training in all areas.

b. How would you describe the quality and thoroughness of the training provided to teachers?

__X__ Excellent in every respect.

____ Good, but could have been improved upon.

____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

c. How would you describe the quality and thoroughness of the training provided to principals?

____ Excellent in every respect.

____ Good, but could have been improved upon.

__X__ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Principals not trained.

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Comments: _____

_____

_____

4. Project leadership at the central office level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

__X__ Excellent throughout the structure.

_____ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

If you checked either of the last two responses, please explain need for improvement. Leadership role is well defined. We now know who has what responsibilities and where we are headed.

_____

b. Was project leadership a significant determinant of project success at the central office level?

__X__ Yes _____ No

Comments: There were too many responsibilities for one person prior to this year.

_____

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Superintendent

_____ Assistant Superintendent

__X__ Supervisor for Health Education

_____ Other, please specify

5. Project leadership at school level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

_____ Good in most instances.

__X__ Fair but needed some additional motivation at critical levels.

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If you checked either of the last two responses, please explain need for improvement. Many principals were not trained; thus, it is very difficult for them to show leadership in the health curriculum.

b. Was project leadership a significant determinant of project success at the school level?

__X__ Yes _____ No

Comments: _____

c. If yes for above question, who generally provided the needed leadership? (Cehck as many as apply.)

_____ Principal

__X__ Classroom teachers

_____ Other (specify)

6. Availability of Community Resources.

a. Was the availability of community resources a factor in project success?

_____ Yes __X__ No

Comments: _____

b. Was any training or orientation provided community personnel who worked in the project? _____ Yes __X__ No

Comments: _____

c. Name several community resources (human and material) which proved important to project implementation.

American Cancer Society

American Lung Association

National Dairy Council

Community Rescue Agencies

Washington County Health Department

Local Physicians

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Comments: _____

_____

_____

C. Project Maintenance. (Activities seen as necessary to keeping the project on target once implemented.)

1. Has project maintenance placed an increased strain on system resources?

_____ Yes __X__ No If yes, explain. As material was lost or destroyed, there were no funds available to replace them. No funds to train more teachers.

2. What, if anything, needs to be done to assure continued top management (Board and Superintendent) support for the project?

Financial support from our elected board of education.

_____

_____

_____

3. What is being done to assure continuing community involvement?

NA at this time.

_____

_____

4. What is being done to assure continued teacher interest and support? (Check those which apply.)

__X__ Additional training and development.

_____ Opportunities to serve as resource people to other teachers in the system.

_____ Opportunities to serve as resource people to other systems.

_____ Other (Please specify). _____

_____

_____

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6. Pupil Interest.

a. Has the maintenance of pupil interest and motivation become a concern since implementation?

____ Yes. _X_ No. If yes, please explain. _____

b. Are there any special efforts to maintain pupil interest? (Check any that apply.)

_X_ Awards programs.

_X_ Special progress reports to students and parents.

____ Changes in program elements.

____ Others (Please specify) Awards have been given to students and volunteers.

C. Have there been any noteworthy adaptations in the project to improve its quality and usefulness to your system? (Explain all that you check.)

____ In areas of personnel development. _____

____ In areas of management. _____

_X_ In areas of materials development and revision. See E

_x_ In areas of leadership (as described above). Principals will be trained. Board level responsibilities are now defined.

____ In areas of community involvement. _____

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_____ To cope with variances in population sparsity or density.

_____ In area of parental inclusion and involvement. _____

D. What have been some of the most noteworthy achievements that have come about as a result of this curriculum improvement effort?

E. Future Plans (Changes or improvements anticipated over next 5 years.)

Please describe any plans or expectations that you and/or the system holds for program improvement and change over the next five years. If these changes involve the elimination or integration of the health curriculum with other curricula elements, please explain.

We have two county developed "hands-on" science units in grades four and five. This summer we plan to develop another science unit and a health unit for grades four and five.

The health unit will be based on the "Best of Berkeley." It will be a "hands-on unit" that will not require sharing of materials between schools.

We hope to have both the science and health implemented into our curriculum for the 1983-84 school year.

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Health Curriculum Project

Evaluation Form I

Allegany County
Primary Grades Proje
(Complete Title)

Directions: This form is to be completed by the person(s) directly responsible for project implementation. The person(s) completing this form should be those most knowledgeable about the project's development, implementation, and adaptation since its inception. Since this task encompasses such a broad range of activities over an extended period of time, the person responsible for completing the form may need to seek advice and information from others in the district who are associated with the project.

A. Current status of the implementation of the project. (Check the appropriate response and complete the comment section as necessary.)

1. Project Status

X Fully in place throughout the system, all schools participating.
____ Almost fully in place, with most (over 75%) schools participating.
____ Partially in place with about half of the schools participating.
____ Barely in place with only a few schools (25% or less) participating.
____ Not in place at all.

Comments: _____

_____

_____

2. Has the Board of Education formally adopted this project?

Yes	No
X	___

Comments: Satisfies the State mandate for a health education program.

_____

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3. If the project has not been fully implemented, what are the plans for further implementation?

4. Quantitative Data: Program Size

Total Elem. Schools in System	Total Elem. Enrollment	No. of Schools in Project	Total Students in Project Schools
22	3,247	22	3,247

Comments:

B. Significant Implementation Steps and Procedures:

1. Management

a. Has project management and supervisory responsibility been clearly established?

X Yes ____ No (If no, indicate status) ____

b. Is the management/supervisory role a newly created position or was this responsibility attached to an existing role?

Attached to existing roles

c. Briefly describe the position and the responsibilities of the person charged with this responsibility. Serve as supervisor of elementary schools responsible for supervision of all areas of the curriculum and teachers in eight schools.

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c. How would you describe the quality of project management?

X Well managed with only routine difficulties.

____ Well managed but with some major difficulties that were completely resolved.

____ Management was indefinite and not well defined at outset but improved as project developed so current status is solid.

____ Other (please specify) _____

Comments: _____

2. Materials utilization and control?

a. Have project materials proven to be satisfactory in most instances?

X Yes ____ No. If no, explain. Materials for replacement become a concern because they are no longer available from publishers or a.v. jobbers.

b. Has materials control (distribution and inventory) been a problem of significance?

____ Yes X No. If yes, please explain. Could become one as school system budget decreases occur.

c. Do material replacement costs pose a problem or question for the program's future?

____ Yes X No. If yes, please explain. We are addressing this problem at the present time.

d. Who is responsible for materials control?

At the system level Supervisor of Elementary Education - Mary Malamphy

At the school level Principal

At the classroom level Teacher

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e. Have any procedures been established for materials control beyond those normally functioning in the system?

__X__ Yes _____ No. If yes, please describe. An aide contributing 30% of his/her time has been available at the county housing site to inventory materials, to prepare kits for distribution, and to provide on-going servicing as needed during the school year.

3. Personnel Development

a. Were all participating principals and teachers provided orientation and training for the project prior to implementation?
Principals __X__ Yes _____ No Classroom teachers __X__ Yes ___

If no, please describe any variance.

Some training has been on the job with lead teachers providing assistance where teaching assignments have been changed due to reduced staffing.

b. How would you describe the quality and thoroughness of the training provided to teachers?

_____ Excellent in every respect.

__X__ Good, but could have been improved upon.

_____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Subsequent training after implementation would be beneficial for all personnel involved. New health knowledge and introduction of revised guides would be better handled during sessions.

c. How would you describe the quality and thoroughness of the training provided to principals?

_____ Excellent in every respect.

__X__ Good, but could have been improved upon.

_____ Inadequate for implementation needs.

If you checked the last two options, please describe needed improvements.

Same as above.

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Comments: _____

_____

_____

4. Project leadership at the central office level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

__X__ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

If you checked either of the last two responses, please explain need for improvement. A supervisor who could allocate at least 40% of his/her time to health program supervision and maintenance would enhance the quality of the program.

b. Was project leadership a significant determinant of project success at the central office level?

__X__ Yes _____ No

Comments: Responsibility of same person since 1972.

_____

_____

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

_____ Superintendent

__X__ Assistant Superintendent Delegated responsibility for implementation to person listed below.

_____ Supervisor for Health Education

__X__ Other, please specify Supervisor of Elementary Education

5. Project leadership at school level. (Commitment and involvement of key personnel at all levels to project success.)

a. How would you describe project leadership as defined above?

_____ Excellent throughout the structure.

__X__ Good in most instances.

_____ Fair but needed some additional motivation at critical levels.

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If you checked either of the last two responses, please explain need for improvement. Health program responsibility just one of many required of project coordinator

b. Was project leadership a significant determinant of project success at the school level?

X Yes ____ No

Comments: Principal involvement in team training resulted in personal commitment for optimal program implementation at school level.

c. If yes for above question, who generally provided the needed leadership? (Check as many as apply.)

X Principal

X Classroom teachers

____ Other (specify)

6. Availability of Community Resources.

a. Was the availability of community resources a factor in project success?

X Yes ____ No

Comments: ____

b. Was any training or orientation provided community personnel who worked in the project? x Yes ____ No

Comments: Originally county health nurses were involved in training sessions. Community agency personnel often participated during teacher training sessions.

c. Name several community resources (human and material) which proved important to project implementation.

Lung Association Cancer Society
Red Cross
Heart Association
Health Department Personnel, Dental Hygienists
Rescue Squads and Fire Departments
Frostburg State College, Allegany Community College
Dental Society
Sacred Heart and Memorial Hospitals

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Comments: _____

_____

_____

C. Project Maintenance. (Activities seen as necessary to keeping the project on target once implemented.)

1. Has project maintenance placed an increased strain on system resources?

X Yes _____ No If yes, explain. Since the health program has been a priority, funding each fiscal year has been available for program maintenance.

2. What, if anything, needs to be done to assure continued top management (Board and Superintendent) support for the project?

_____

_____

_____

_____

3. What is being done to assure continuing community involvement?

Continuing contact with community agencies from central office project leader

_____

4. What is being done to assure continued teacher interest and support? (Check those which apply.)

_____ Additional training and development.

X Opportunities to serve as resource people to other teachers in the system. Training component involves model school personnel in any subsequent training.

_____ Opportunities to serve as resource people to other systems.

X Other (Please specify). Each teacher is aware that the health program continues to be a vital part of the elementary program. Many Project Basic competencies are an integral part of the health curriculum. No additional survival skill activities need to be included in other curriculum areas to assure Project Basic compliance. All teachers are required to teach Project Basic.

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6. Pupil Interest.

a. Has the maintenance of pupil interest and motivation become a concern since implementation?

____ Yes. _X_ No. If yes, please explain. _____

b. Are there any special efforts to maintain pupil interest? (Check any that apply.)

____ Awards programs.

____ Special progress reports to students and parents.

_X_ Changes in program elements.

____ Others (Please specify) Duplication of experiences eliminated at subsequent grade levels K - 3 as program was implemented.

C. Have there been any noteworthy adaptations in the project to improve its quality and usefulness to your system? (Explain all that you check.)

____ In areas of personnel development. _____

____ In areas of management. _____

____ In areas of materials development and revision. There will be a workshop conducted in May, 1983 to update, revise and purchase new materials to replace those no longer available.

____ In areas of leadership (as described above). _____

____ In areas of community involvement. _____

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_____ To cope with variances in population sparsity or density.

_____

_____

_____

_____ In area of parental inclusion and involvement. _____

_____

_____

D. What have been some of the most noteworthy achievements that have come about as a result of this curriculum improvement effort?

_____

_____

_____

_____

_____

_____

_____

_____

E. Future Plans (Changes or improvements anticipated over next 5 years.)

Please describe any plans or expectations that you and/or the system holds for program improvement and change over the next five years. If these changes involve the elimination or integration of the health curriculum with other curricula elements, please explain.

Program update and material replacement will occur and contribute to program maintenance during the next five years. Periodic review and imput from administrative and instructional personnel will ensure that current level of commitment and program implementation is maintained.

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Appendix D

Sample Schedules

BOARD OF EDUCATION OF ALLEGANY COUNTY

108 WASHINGTON STREET, P. O. BOX 1608, CUMBERLAND, MARYLAND 21502-0439

TELEPHONE (301) 759-2000

H. WILLIAM MITCHELL
SUPERINTENDENT

TO: Principals of Elementary Schools DATE: August 23, 1982

FROM: Mary Malamphy, Supervisor of Elementary Education

SUBJECT: Schedule for Obtaining Lungs and Hearts from Frostburg Meats for the Berkeley Health Project, 1982-83

I am pleased that Mr. J. C. DiNicola, Frostburg Meats, has agreed to supply hog lungs and hearts for dissection during Phase III of the Berkeley Health units again this year.

Slaughtering occurs on Monday and Tuesday at Frostburg Meats. Mr. DiNicola delivers to the Cumberland area on Monday and Wednesday and to the George's Creek area on Friday. Delivery to other areas of the county occurs on Tuesday and Thursday. He will deliver the lungs and the hearts to the schools on the day of the week which the delivery truck is in the area. He has volunteered to freeze the lungs and hearts when the delivery of the specimens occurs late in the week.

Each principal should contact Mr. DiNicola two weeks prior to the day of dissection to determine the delivery date and the number of specimens needed for your school. There will be no charge for the lungs; however, since the hearts are used for making pudding, there will be a charge for them. The bill for the hearts will be included with the specimens.

I have asked Mr. DiNicola to include at least one set of lungs with the trachea and heart attached so it can be used for demonstration purposes. The hearts will be mutilated as little as possible during the inspection process so the parts can be explored during the dissection.

I hope that this arrangement for securing lung and heart specimens will be as satisfactory this year as it was in the past. Mr. DiNicola has been most gracious and cooperative in setting up the procurement and delivery procedure.

A schedule is attached which reflects the week when each school should be involved in the heart and lung dissections. The principal and teacher will need to schedule the day to coincide with Frostburg Meats' delivery date to your area. If you prefer, you may arrange for a staff member from your school to pick up the specimens. Please let Mr. DiNicola know that a person from your school will transport the specimens so he can inform you about the most convenient time for pickup.

Frostburg Meats' Telephone Number: 689-8945
Mr. J. C. DiNicola, owner

Mr. DiNicola will receive a copy of this communication. If you will not be using specimens from Frostburg Meats, please call me so I can inform Mr. DiNicola.

Please feel free to call me if there is a problem with this arrangement.

HEART DISSECTION - 1982-83

Beall Elementary	October 18-22
Barton	October 25-29
Mt. Savage	November 1-5
Cresaptown	November 8-12
Eckhart	November 15-19
Frost	November 22 - December 3
Johnson Heights	December 6-10
Flintstone	December 13-17
George's Creek	January 17-21
Gephart	February 7-11.
Parkside	February 21-25
Westernport	February 28 - March 4
Cash Valley	March 7-11
East Side	March 14-18
Columbia Street	March 28 - April 1
Northeast	April 11-15
West Side	April 18-22
South Penn	April 25-29

LUNG DISSECTION - 1982-83

Johnson Heights	October 18-22
Northeast	October 25-29
Mt. Savage	November 1-5
George's Creek	November 8-12
Frost	November 15-19
Bel Air	December 6-10
Cresaptown	December 13-17
Parkside	February 7-11
John Humbird	February 14-19
East Side	March 7-14
McCoole	March 28 - April 1

SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 FROST	Sept. 13 - 17	Sept. 20 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 3
Kit 2 EAST SIDE	Sept. 20 - 24	Sept. 27 - Oct. 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 10
Kit 3 WESTERNPORT	Sept. 27 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 Dec. 10	Dec. 13 - 27
Kit 4 McCOOLE	Oct. 4 - 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Dec. 20 - 23
Kit 5 ECKHART	Oct. 11 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 7
Kit 6 CASH VALLEY	Oct. 18 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 21
Kit 7 BARTON	Oct. 25 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 14	Jan. 17 - 21
Kit 8 CRESAPTOWN	Nov. 1 - 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 4

SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 GEPHART	Nov. 15 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 18
Kit 2 SOUTH PENN	Nov. 29 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 4
Kit 3 GEORGE'S CREEK	Dec. 6 - 10	Dec. 13 - 23	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 3
Kit 4 NORTHEAST	Jan. 3 - 7	Jan. 10 - 21	Jan. 24 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 24
Kit 5 BEALL ELEMENTARY	Jan. 10 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - 31
Kit 6 BEL AIR	Jan. 17 - 21	Jan. 24 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 29	March 30 - 31
Kit 7 COLUMBIA STREET	Jan. 24 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - April 15	April 18 - 20
Kit 8 FLINTSTONE	Jan. 31 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - 27

SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 JOHN HUMBIRD	Feb. 14 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 11
Kit 2 JOHNSON HEIGHTS	Feb. 21 - 25	March 28 - March 11	March 14 - 25	March 28 - April 15	April 18 - 29	May 2 - 13	May 16 - 18
Kit 3 MT. SAVAGE	Feb. 28 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 20	May 23 - 25
Kit 4 OLDTOWN	March 7 - 11	March 14 - 25	March 28 - April 15	April 18 - 29	May 2 - 13	May 16 - 27	May 31 - June 3
Kit 5 PARKSIDE	March 14 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 20	May 23 - June 3	June 6 - 8
Kit 6 WEST SIDE	March 14 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 20	May 23 - June 3	June 6 - 8

Routing Schedule
PGHCP
1982-83

Kit #1	Beginning date	Ending date	Kit #2	Beginning date	Ending date
Frost	9/13/82	12/3/82	East Side	9/20/82	12/10/82
Gephart	11/15/82	2/18/83	South Penn	11/29/82	3/3/83
John Humbird	2/14/83	5/11/83	Johnson Heights	2/21/83	5/18/83
Kit #3			**Kit #4**		
Westernport	9/27/82	12/17/82	McCoole	10/4/82	12/23/82
George's Creek	12/6/82	3/3/83	Northeast	1/3/83	3/24/83
Mt. Savage	2/28/83	5/25/83	Oldtown	3/7/83	6/3/83
Kit #5			**Kit #6**		
Eckhart	10/11/82	12/22/83	Cash Valley	10/18/82	1/21/83
Beall Elementary	1/10/83	3/31/83	Bel Air	1/17/83	3/31/83
Parkside	3/14/83	6/8/83	West Side	3/14/83	6/8/83
Kit #7			**Kit #8**		
Barton	10/25/82	1/21/83	Cresaptown	11/1/82	2/4/83
Columbia Street	1/24/83	4/20/83	Flintstone	1/31/82	4/27/83

Note: Dates for beginning and ending the unit are listed above. Please note the unit starting date for the school following yours and be certain to send the Introduction Phases I, and II to the receiving school at least two weeks prior to that date. This will enable the receiving school to begin the unit at the designated time on the schedule.

The complete kit may be assembled and sent at one time in situations where the unit will be completed at least two weeks prior to the date for initiating the unit at the receiving school.

SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 WEST SIDE (50)	Sept. 13 - 17	Sept. 20 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 3
Kit 2 CASH VALLEY (67)	Sept. 20 - 24	Sept. 27 - Oct. 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 10
Kit 3 MT. SAVAGE (33)	Sept. 27 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 17
Kit 4 BARTON (28)	Oct. 4 - 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Dec. 20 - 23
Kit 5 FLINTSTONE (30)	Oct. 11 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 7
Kit 6 WESTERNPORT (42)	Oct. 18 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 21
Kit 7 BEL AIR (50)	Oct. 25 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 14	Jan. 17 - 21
Kit 8 GEORGE'S CREEK (60)	Nov. 1 - 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 4

SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 GEPHART	Nov. 8 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec, 13 - 22	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 4
Kit 2 BEALL ELEMENTARY (49)	Nov. 15 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 18
	Nov. 29 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 4
Kit 3 JOHNSON HEIGHTS (45)	Dec. 6 - 10	Dec. 13 - 23	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 3
Kit 4 PARKSIDE (35)	Jan. 3 - 7	Jan. 10 - 21	Jan. 24 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 24
Kit 5 ECKHART	Jan. 10 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - 31
Kit 6 SOUTH PENN (100)	Jan. 17 - 21	Jan. 24 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 29	March 30 - 31
Kit 7 SOUTH PENN	Jan. 24 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - April 15	April 18 - 20

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SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 8 EAST SIDE (33)	Jan. 31 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - 2
Kit 1 FROST (46)	Feb. 7 - 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - April 15	April 18 - 29	May 2 - 4
Kit 2 JOHN HUMBIRD (46)	Feb. 14 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 11
Kit 3 COLUMBIA STREET (35)	Feb. 21 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - April 15	April 18 - 29	May 2 - 13	May 16 - 18
Kit 4 CRESAPTOWN (50)	Feb. 28 - March 4	March 7 - 18	March 21 - March 31	April 11 - 22	April 25 - May 6	May 9 - 20	May 23 - 25
Kit 5 McCOOLE (30)	March 7 - 11	March 14 - 25	March 28 - April 15	April 18 - 29	May 2 - 13	May 16 - 27	May 31 - June 3
Kit 6 OLDTOWN (100)	March 14 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 20	May 23 - June 3	June 6 - 8

Routing Schedule
Digestive System
1982-83

Kit #1	Beginning date	Ending date	Kit #2	Beginning date	Ending date
West Side	9/13/82	12/3/82	Cash Valley	9/20/82	12/10/82
Gephart	11/8/82	2/4/83	Beall Elementary	11/15/82	2/18/83
Frost	2/7/83	5/4/83	John Humbird	2/14/83	5/11/83
Kit #3			**Kit #4**		
Mt. Savage	9/27/82	12/17/82	Barton	10/4/82	12/23/82
Johnson Heights	12/6/82	3/3/83	Parkside	1/3/83	3/24/83
Columbia St.	2/21/83	5/18/83	Cresaptown	2/28/83	5/25/83
Kit #5			**Kit #6**		
Flintstone	10/11/82	1/7/83	Westernport	10/18/82	1/21/83
Eckhart	1/10/83	3/31/83	South Penn	1/17/83	3/31/83
McCoole	3/7/83	6/3/83	Oldtown	3/14/83	6/8/83
Kit #7			**Kit #8**		
Bel Air	10/25/82	1/21/83	George's Creek	11/1/82	2/4/83
South Penn	1/24/83	4/20/83	East Side	1/31/83	4/27/83

Note: Dates for beginning and ending the unit are listed above. Please note the unit starting date for the school following yours and be certain to send the Introduction, Phases I, and II to the receiving school at least two weeks prior to that date. This will enable the receiving school to begin the unit at the designated time on the schedule.

The complete kit may be assembled and sent at one time in situations where the unit will be completed at least two weeks prior to the date for initiating the unit at the receiving school.

SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 JOHNSON HEIGHTS (45)	Sept. 13 - 17	Sept. 20 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 3
Kit 2 NORTHEAST (26)	Sept. 20 - 24	Sept. 27 - Oct. 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 10
Kit 3 MT. SAVAGE (32)	Sept. 27 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 17
Kit 4 GEORGE'S CREEK (60)	Oct. 4 - 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Dec. 20 - 23
Kit 5 FROST (34)	Oct. 11 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 7
Kit 6 & 7 BEL AIR (125)	Nov. 1 - 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 4
Kit 8 CRESAPTOWN (75)	Nov. 8 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 4
Kit 1 & 2 PARKSIDE (50)	Jan. 3 - 7	Jan. 10 - 21	Jan. 24 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 24
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SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 3 & 4 JOHN HUMBIRD (105)	Oct. 10 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - 3
Kit 5 & 8 EAST SIDE (37)	Jan. 31 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - 2
Kit 6 McCOOLE (50)	Feb. 21 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - April 5	April 18 - 29	May 2 - 13	May 16 - 18
190							191

Routing Schedule
Lungs & Respiratory
1982-83

Kit #1	Beginning date	Ending date	Kit #2	Beginning date	Ending date
Johnson Heights	9/13/82	12/3/82	Northeast	9/20/82	12/10/82
Parkside	1/3/83	3/24/83	Parkside	1/3/83	3/24/83
Kit #3			**Kit #4**		
Mt. Savage	9/27/82	12/17/82	George's Creek	10/4/82	12/23/82
John Humbird	1/10/83	3/31/83	John Humbird	1/10/82	3/31/83
Kit #5			**Kit #6**		
Frost	10/11/82	1/7/83	Bel Air	11/1/82	2/4/83
East Side	1/31/83	4/27/83	McCoole	2/21/83	5/18/83
Kit #7			**Kit #8**		
Bel Air	11/1/82	2/4/83	Cresaptown	11/8/82	2/4/83
			East Side	1/31/83	4/27/83

Note: Dates for beginning and ending the unit are listed above. Please note the unit starting date for the school following yours and be certain to send the Introduction Phases I, and II to the receiving school at least two weeks prior to that date. This will enable the receiving school to begin the unit at the designated time on the schedule.

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. SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 BEALL ELEMENTARY (110)	Sept. 13 - 17	Sept. 20 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 3
Kit 2 BARTON (65)	Sept. 20 - 24	Sept. 27 - Oct. 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 10
Kit 3 MT. SAVAGE (33)	Sept. 27 - Oct. 1	Oct. 4 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 17
Kit 4 CRESAPTOWN (50)	Oct. 4 - 8	Oct. 11 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Dec. 20 - 23
Kit 5 ECKHART	Oct. 11 - 15	Oct. 18 - 29	Nov. 1 - 12	Nov. 15 - 26	Dec. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 7
Kit 6 FROST (63)	Oct. 18 - 22	Oct. 25 - Nov. 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 21
Kit 7 JOHNSON HEIGHTS (55)	Oct. 25 - 29	Nov. 1 - 12	Nov. 15 - 26	Nov. 29 - Dec. 10	Dec. 13 - 22	Jan. 3 - 14	Jan. 17 - 21
Kit 8 FLINTSTONE (80)	Nov. 1 - 5	Nov. 8 - 19	Nov. 22 - Dec. 3	Dec. 6 - 17	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 4
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SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 GEORGE'S CREEK (65)	Dec. 6 - 10	Dec. 13 - 23	Jan. 3 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 3
Kit 2 GEPHART	Jan. 3 - 7	Jan. 10 - 21	Jan. 24 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 2
Kit 3 PARKSIDE (65)	Jan. 10 - 14	Jan. 17 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - 3
Kit 4 WESTERNPORT (77)	Jan. 17 - 21	Jan. 24 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 29	March 30 - 3
Kit 5 CASH VALLEY (120)	Jan. 24 - 28	Jan. 31 - Feb. 11	Feb. 14 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - April 15	April 18 - 2
Kit 6 EAST SIDE (43)	Jan. 31 - Feb. 4	Feb. 7 - 18	Feb. 21 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - 2
Kit 7 COLUMBIA STREET (75)	Feb. 21 - 25	Feb. 28 - March 11	March 14 - 25	March 28 - April 15	April 18 - 29	May 2 - 13	May 16 - 18
Kit 8 NORTHEAST (27)	Feb. 28 - March 4	March 7 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 20	May 23 - 25

SCHOOL	INTRODUCTION	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V	CULMINATION
Kit 1 WEST SIDE (96)	March 7 - 11	March 14 - 25	March 28 - April 15	April 18 - 29	May 2 - 13	May 16 - 27	May 31 - June 3
Kit 2 SOUTH PENN (92)	March 14 - 18	March 21 - 31	April 11 - 22	April 25 - May 6	May 9 - 20	May 23 - June 3	June 6 - 8
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Routing Schedule
Heart & Circulatory Unit
1982-83

Kit #1	Beginning date	Ending date	Kit #2	Beginning date	Ending date
Beall Elementary	9/13/82	12/3/82	Barton	9/20/82	12/10/82
George's Creek	12/6/82	3/3/83	Gephart	1/3/83	3/25/83
West Side	3/7/83	6/3/83	South Penn	3/14/83	6/8/83
Kit #3			**Kit #4**		
Mt. Savage	9/27/82	12/17/82	Cresaptown	10/4/82	12/23/82
Parkside	1/10/83	3/31/83	Westernport	1/7/83	3/31/83
Kit #5			**Kit #6**		
Eckhart	10/11/82	1/7/83	Frost	10/18/82	1/21/83
Cash Valley	1/24/83	4/20/83	East Side	1/31/83	4/27/83
Kit #7			**Kit #8**		
Johnson Heights	10/25/82	1/21/82	Flintstone	11/1/82	2/4/83
Columbia Street	2/21/83	5/18/83	Northeast	2/28/83	5/25/83

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Revised Health Kit Schedule * 8/30/82

PRIMARY HEALTH KITS SCHEDULE

1982-83
REVISED: 7/28/82

Copy to: ✓ Yoder Principal
✓ L. Lynn. "
✓ ✓ B.F + D.R. media spon

	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.
KIT I - Green	✓ *Grantsville			Kitzmiller			Red House					
KIT II - Red	Accident			Bloomington			Route 40					
KIT III - Yellow	1 ∞ 2 Crellin		Nov. ←	Swan Meadow (1st grade)			*Friendsville					
KIT IV - Blue	Yoder *			*Broad Ford			*Broad Ford					
KIT V - Orange	Loch Lynn *			*Dennett Road			*Dennett Road					

*School Media person at this school responsible for Kit's Inventory.

7/23/82
CET:dhn

BOARD OF EDUCATION OF GARRETT COUNTY
40 South Fourth Street
P. O. Box 313
Oakland, Maryland 21550

Office of the Superintendent

(Area Code 301)
Telephone: 334-8121

PRIMARY GRADES HEALTH CURRICULUM MATERIALS SCHEDULE

1981-82 SCHOOL YEAR

CHARLEEN EVANS THOMAS, INSTRUCTIONAL SUPERVISOR

SCHEDULE FOR KITS I AND II

Accident, Bloomington, Crellin, Dennett Road, Friendsville, Grantsville, Kitzmiller, Loch Lynn, Red House, Route 40, Swan Meadow, and Yoder Schools

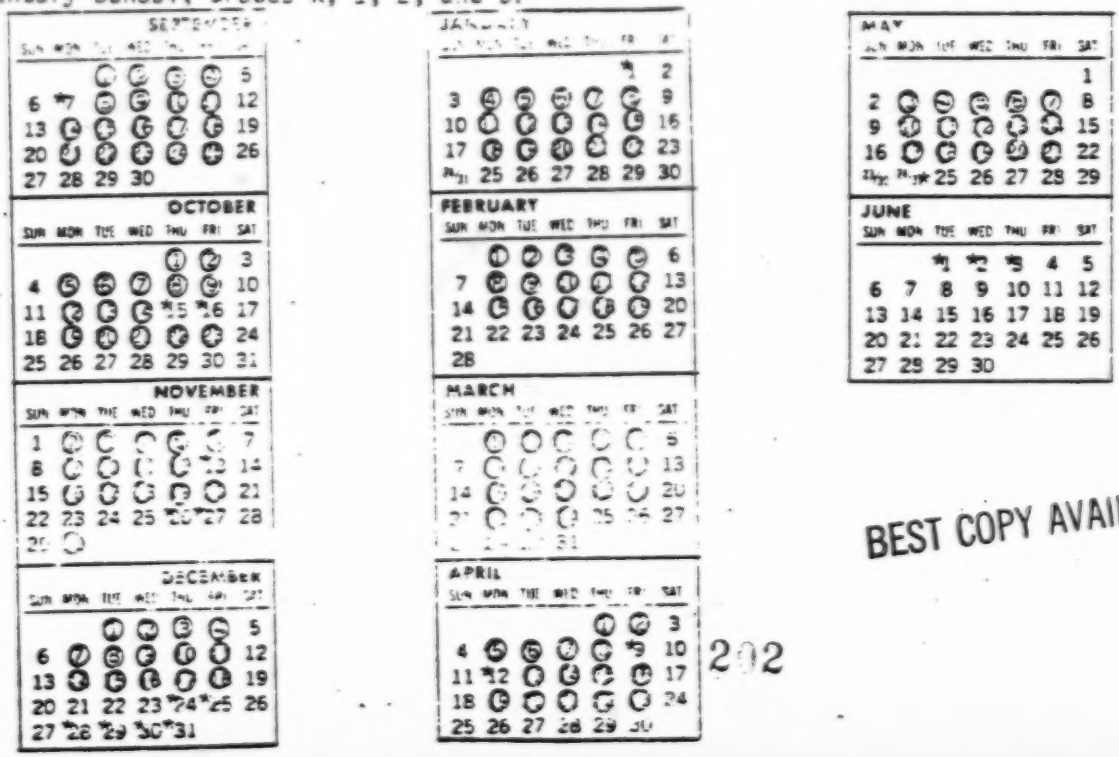
Days marked by circles designate days that the primary grades health curriculum is being taught in Garrett County Schools according to the attached materials' schedule.

Days designated with a * are days that students are not in session (excluding weekends and starred dates).

Days not circled are those days in which the materials MUST travel via "PONY" in order that all materials may be used by each school. If a school is not finished with a particular phase in the allotted time, the materials still MUST be sent on!

Principals are requested to monitor their school's shipment of materials out of the school on time or are requested to appoint a designee in each school to see that shipment out is complete!

Next health curriculum inservice days are June 2, 3, 4, 1982 at Dennett Road Elementary School, Grades K, 1, 2, and 3.



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1981-82

REVISED - (BECAUSE WE'RE GETTING AN EXTRA KIT!)

PRIMARY GRADES HEALTH CURRICULUM MATERIALS SCHEDULE

(This curriculum to be taught in 1981-82 school year only in the grades of each school where that particular teacher has had the Project's three-day inservice training.)*

SCHOOLS: Grades circled designates those where a teacher has received training.

KIT I (Green)

DATE KIT ARRIVES / DATE KIT LEAVES	Nov. 2- Nov. 20	Nov. 30 Dec. 18	Jan. 4- Jan. 22	Feb. 1- Feb. 19	Mar. 1- Mar. 24	Apr. 1- Apr. 23	May 3- May 21
(K)-(1)-(2)-(3) Grantsville	This school may utilize Kit I as needed up to 2/19, moving Intro 10/23, Ph. I 11/20, Ph. II 12/18, Ph. III 1/22, Ph. IV 2/19, Ph. V 3/24 on to Kitzmiller.						
(K)-(1)-(2)-(3) Kitzmiller	Intro	Phase I	Phase II	Phase III	Phase IV	Phase V	
(K)-(1)-(2)-(3) Red House		Intro	Phase I	Phase II	Phase III	Phase IV	Phase V

Return Intro and All Phases to Grantsville School for storage.

KIT II (Red)

(K)- 1 - 2 - 3 Accident	Intro	Phase I	Phase II	Phase III	Phase IV	Phase V	
1 -(2)- 3 Swan Meadow	Intro	Phase I	Phase II	Phase III	Phase IV	Phase V	
K -(1)- 2 -(3) Friendsville	Intro	Phase I	Phase II	Phase III	Phase IV	Phase V	
(K)- 1 -(2)-(3) Bloomington		Intro	Phase I	Phase II	Phase III	Phase IV	Phase V
K -(1)- 2 - 3 Route 40		Intro	Phase I	Phase II	Phase III	Phase IV	Phase V

Return Intro and All Phases Retained at Bloomington for storage.

KIT III (Yellow)

(K)-(1)-(2)-(3) Broad Ford	This school may utilize the Kit III, commencing around 1/18/82, completing the program by May 30, 1982. Kit is retained for summer at Broad Ford School.

KIT IV (Blue)

(K)- 1 - 2 - 3 Crellin K -(1)- 2 - 3 Loch Lynn	These schools may utilize the Kit IV commencing around 1/18/82, completing the program by May 21, 1982. Kit is sent to Friendsville for storage.

1981-82
REVISED - (BECAUSE WE'RE GETTING AN EXTRA KIT!)

PRINARY GRADES HEALTH CURRICULUM MATERIALS SCHEDULE

(This curriculum to be taught in 1981-82 school year only in the grades of each school where that particular teacher has had the Project's three-day inservice training.)

SCHOOLS: Grades circled designates those where a teacher has received training.

KIT V (Orange)

DATE KIT ARRIVES DATE KIT LEAVES	Nov. 2- Nov. 20	Nov. 30 Dec. 18	Jan. 4- Jan. 22	Feb. 1- Feb. 19	Mar. 1- Mar. 24	Apr. 1- Apr. 23	May 3- May 21
(K)-(1)-(2)-(3) Dennett Road	This school may utilize the Kit V all year long except for those periods noted below when certain Phases for Grade 1 only go to Yoder School and will then be returned to Dennett Road for storage.						
-(1)- 2 - 3 Yoder	Gr. 1 Intro	Gr. 1 Phase I	Gr. 1 Phase II	Gr. 1 PhaseIII	Gr. 1 Phase IV	Gr. 1. Phase V	
(K)-(1)-(2)-(3) Dennett Road		Intro return to D.Rd.	Phase I return to D.Rd	Phase II return to D.Rd	PhaseIII return to D.Rd	Phase IV return to D.Rd.	Phase V return to D.Rd